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ABSTRACT

This publication consists of papers presented at the 1969 Annual Institute for Public Health Social Workers. The theme of the institute focused on family planning in the context of maternal and child health services, on examples of social work practice in family planning, and on the educational needs of social workers as related to this practice. In Part I of the publication, papers concerning the sociological, public health, and medical aspects of family planning are presented. The papers in Part II are directed more specifically to the social worker's role in family planning. Papers that deal with social work education and family planning are presented in Part III. Names and addresses of members of the planning committee, of the Institute faculty, and of participants in the institute as well as a program schedule are provided in the Appendix. (Author/RM)

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The Social Worker and Family Planning

**BASED ON THE PROCEEDINGS OF
THE 1969 ANNUAL INSTITUTE FOR
PUBLIC HEALTH SOCIAL WORKERS**

**Supported by a grant from
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Edited by JOANNA F. GORMAN

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Preface

This publication is based on the Proceedings of the 1969 Institute for social workers in maternal and child health and other public health programs in Regions VIII and IX of the Department of Health, Education and Welfare. Both the Institute and this publication have been made possible by a grant from the Maternal and Child Health Service, Health Services and Mental Health Administration, Public Health Service, U.S. Department of Health, Education and Welfare, formerly the Health Services Division of the Children's Bureau.

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Without all of these people and many more the Institute and this publication would not have been possible.

Joanna F. Gorman

June, 1970

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The Social Worker and Family Planning: An Introduction

JOANNA F. GORMAN

The theme of this Institute on the Social Worker and Family Planning was focused on family planning in the context of maternal and child health services, on examples of social work practice in family planning, and on the educational needs of social workers as related to this practice. Deliberately omitted from the program were the subjects of population planning and population control. While these are worthy subjects in their own right, the Planning Committee decided to concentrate the three-day program on the topics mentioned above.

In Part I of this volume we have grouped the papers concerning the sociological, public health, and medical aspects of family planning. The differing opinions expressed by the speakers regarding the organization and delivery of family planning services reflect the varying ways in which these services are being viewed throughout the country. The first two papers, by Lee Rainwater, Ph.D., and Helen Wallace, M.D., present two different approaches to service delivery, a topic which is discussed further by the panel on cultural perspectives. Medical and psychological aspects of contraception are presented in the papers by Sadja Goldsmith, M.D., and Edwin Gold, M.D.

Two demonstrations which augmented these papers unfortunately had to be omitted because they could not be presented effectively in a publication. One demonstration dealt with teaching and counseling in a family planning clinic,* and the other demonstration dealt with the team approach to family planning.** It was necessary also to omit several other presentations.***

The papers in Part II are directed more specifically to the social worker's role in family planning. Beginning with the resolution of the 1967 Delegate Assembly of the National Association of Social

*Presented by Lucille Wolfe, R.N., Director, Family Planning Clinic, Los Angeles County General Hospital.

**Presented by the staff of the Family Planning Clinic, Maternity and Infant Care Project, Berkeley (Calif.) City Health Department. The panel included Kathleen A. Malloy, M.D., M.P.H., Director; Laura Anderson, M.P.H., Coordinator; Janice Friesen, M.S.W., Social Worker; James Jackson, M.D., Obstetrician; and Ida Castillo, Jean Brooks, and Emma Hunter, Family Planning Aides.

***For complete program, see appendix.

Workers on the responsibility of social workers in family planning, Miriam Mednick sets the stage by illustrating a variety of practice situations in which social workers have both an opportunity and an obligation to make family planning information and services available. Jane Collins continues the illustration by describing the family planning activities of social workers in a family health service. Kazuye Kumabe reports on a research study undertaken by social workers in Hawaii to assess the factors influencing the use of contraception, and she discusses their implications for social work practice. Leah Potts considers the role of social workers when planning fails and abortion counseling is sought; and Sylvia Schild talks about genetic counseling.

The papers in Part III deal with social work education and family planning. Alice Varela suggests a plan for developing an in-service education program. Florence ~~McKern~~ ~~McKern~~ examines the curricula of graduate schools of social work and suggests some approaches to the inclusion of family planning content.

Part I

SOCIOLOGICAL, PUBLIC HEALTH, AND MEDICAL ASPECTS OF FAMILY PLANNING

Family Planning in the United States

LEE RAINWATER, Ph.D.*

In the past ten years there has been a major revolution in family planning in the United States. This revolution has affected the technology, the social organization, and the ideological context of family planning efforts. The development of the oral contraceptive and the intrauterine device have made obsolete many of our ideas about what was and what was not necessary to organize family planning services. The growing potentialities for widespread service facilities through expanded Planned Parenthood activities, city facilities and special poverty programs have significantly changed the limits on delivery of service. Finally, the growing awareness of the social necessity for family limitation, and the opting for a pluralistic position by many Catholic organizations has meant a great deal more openness about planning for family limitation services and the removal of many road-blocks to family planning through public facilities.

Not that the millennium has arrived, but at least a good many of the special disabilities under which family planning (as opposed to other kinds of medical services) has operated have been removed. Given these changes, it behooves us to consider factors affecting adoption of family planning by low-income groups in a new light.

Let me review first the situation before the technological innovations and then suggest some of the ways in which social and psychological factors operate in the present as opposed to the past. We can discuss contraceptive behavior in terms of generalized attitudes toward the possibility of planning a family, in terms of the discussions husbands and wives have on this subject, in terms of the kinds of methods known and used, and, finally, in terms of the effectiveness with which they are used.

Several different approaches to the whole question of how one might plan a family and limit the number of children one has are apparent when couples are interviewed. Some couples approach this subject in a very planful and taken-for-granted way. They are interested in the technical aspects of contraception. They expect to be able to plan their families and they feel that they have developed routines which make it possible for them to do so. Other couples are hopeful on this score but uncertain. They are not sure that what they are doing will work. Somewhat like the feelings the typical suburbanite has toward his lawn, their general attitude is one of involved and optimistic uncertainty. Finally, some couples display an attitude of relatively low optimism which can be summarized as fatalistic. That is a sense of going through the motions of family planning or any other activity that is performed with a rather low confidence that one's abilities will

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suffice to achieve the desired goal. They have a tendency, therefore, not to be particularly involved in the mechanisms of family planning.

The first attitude, the playful one, seems by far the most common among middle class couples, particularly Protestants, and much less common among working class couples, particularly those at the very bottom class level. Whatever their particular knowledge of contraceptive methods or the strength of their personal desires to limit their families, couples at the lowest class level show relatively little confidence that they will be able to make successful use of the methods they know about.

These patterns of overall attitude toward the subject of family planning tend to go along with particular patterns of husband-wife discussions on the subject of contraception and family limitation. By and large there is full discussion early in a marriage among middle class Protestants. This is somewhat less characteristic of middle class Catholics who tend to have only casual discussions of the subject and particularly among those who expect to have large families and do not think it necessary to concern themselves with the problem of family planning and limitation until fairly far along in their childbearing history. At this later phase, however, most middle class Catholics do begin to discuss family planning fully and seriously and bring the subject more centrally into their marital planning.

Within the lower class there is a strong tendency among Protestants and Catholics, Negroes and whites alike, to postpone full discussion of this marital task until fairly late in a couple's childbearing history. It is much more common among lower-lower class couples not to discuss the subject more than casually, even after having more children than either partner wished.

As other researchers have noted, particularly Hill, Stycos and Back, 1957, the resources for communication and cooperative decision making in lower class families are often not up to the task of making and carrying out sensible decisions about contraception even when there is the desire for family limitation on the part of both partners.

In the early 1960's, my data indicated a widespread knowledge of the existence of different contraceptive methods among all class groups. Only among lower-lower class Catholic women were there more than four per cent of the respondents who were not able to name at least one contraceptive method. Although the number of methods of which individuals were aware varied markedly by social class (with middle class people able to name more methods than lower class people), it also was clear that even at the lower class level there existed knowledge of one or two methods which had the capacity of limiting conception. Therefore, the principal issue is not lack of simple basic knowledge about the existence of devices that would enable them to limit their families.

Middle and lower class people differ in the ways they think about the effectiveness of family planning. Middle class people have high confidence in some methods--condom, diaphragm, pills--and a low expectation of failure. They tend to believe that most people have "accidents" because they are too ignorant to use effective methods, do

not use effective methods correctly, are sloppy, or take a chance. In other words, middle class people tend to differentiate methods rather sharply in terms of effective and ineffective ones, and to differentiate users in terms of how competent they are at using the method.

In the lower class these distinctions are very much blurred. There is a tendency to see the most effective methods as perhaps proving adequate only if you are lucky. There is a similar tendency not to see competence in using contraceptive methods as paying off, but rather to feel that one is always at the mercy of the method's inherent shortcomings. Thus lower class people are much more likely to blame the method, much less likely to blame the user.

The couples in my sample were categorized as either effective or ineffective contraceptive practitioners on the basis of their description of the methods that they used and the way they used them. While this is a rough categorization, it does represent the typical practice of couples as they were able to report it to us.

I hypothesized that the less the separation of the spouses in a marital relationship, the more effective contraceptive practice would be. This proved to be true both before and after the birth of the last wanted child, but particularly in the latter case. I take this to be indicative of the importance of communication between husband and wife, and of a husband's involvement in family issues. In the more segregated relationships it was much more common for a husband to regard the whole question of family planning as mainly his wife's business.

I also found a positive relationship between effectiveness at contraception and the extent to which a wife indicated she found sexual relations with her husband gratifying. This relationship did not hold for Catholics but only for lower class white Protestants and Negroes.

The relationship between sexual gratification and contraceptive effectiveness is a complex one and seems also related to the nature of the marital relationship. A highly separated marital relationship makes it difficult for couples to function in the close cooperation required of both for mutually gratifying sexual relations and for effective contraceptive practice. In this context, contraception tends to become a bone of contention in relation to a wife's wish to avoid anything in connection with sex. Her aversion to sexual relations is reinforced by her anxiety about becoming pregnant, coupled with the difficulties she experiences in doing anything effective to prevent pregnancy.

In a past context, then,--that is before the pill and before the IUD--it seemed that the road to making family planning services widely available to low income populations was going to be a slow, hard and highly expensive one in the sense that it would require a great deal of time per case to teach and help low income families to overcome the kinds of obstacles which personality factors and marital relationships interpose. There was never any question that low income families wanted families as small as those of anyone else in the society, but it was rather that their particular situations made it very difficult for them to achieve those desires.

To the extent that, for one reason or another, it would be necessary today to use these older contraceptive methods, we would still be confronted with these problems which can only be coped with by the relatively time-consuming process of building and maintaining a relationship with many patients in which they can both learn what is necessary to use the method and receive support in their efforts to do so against the obstacles their marital and economic situations pose for them.

In the past, as in the present, a large part of the answer had to do with the availability of family planning services. Obviously, the easier it is for patients to get to clinics, the more patients will come. However, under past conditions it was clear that the rapid extension of services would involve heavy cost because of the amount of professional time that would be involved, the number of visits the patient would have to make to the clinic and the relatively high rate of loss of patients. Now, given the popularity of the pill and the IUD, it seems clear that the major reason that poor people do not limit their families is that they cannot find their way to services easily enough.

A great majority of stable working class and middle class women avail themselves of a physician in connection with maternity, and, if necessary, they obtain contraceptive advice from him. That is, if they don't manage to obtain satisfactory contraception from a method that is available without a prescription, they know to go to a physician for a diaphragm, pills or IUD.

The low income population, the medically indigent, however, use public facilities. Unless these public facilities prove cooperative about contraception, or unless some set of parallel institutions such as Planned Parenthood Clinics are created and are readily available, the low income population simply does not have meaningful access to family planning services. With the newer technology, we simply don't have the same problems, at least to the same extent, of marital communication, ignorance of the body, and so forth as with the earlier methods. In order to take the pill or to have the IUD, wives don't have to discuss the matter in any great detail with their husbands and get his cooperation. So many of the social and psychological factors which interfered with lower class ineffective contraceptive practice with the methods that were available at the beginning of the 1960's simply do not represent the same kind of obstacles today.

Just as Planned Parenthood pioneered the development of Family Planning Clinics as a new kind of institution to make contraception available to people who were not using their own physicians for this, it has pioneered in the medical organization planning that is required for the widest possible extension of this kind of service. Frederick Jaffee has symbolized the experience of seeking to develop such a plan for New York City. Similar, though less extensive programs have also been planned and put in operation in a number of other cities, particularly Washington, D.C.

The first step in this plan was to estimate the number of fertile, medically indigent women who do not desire another pregnancy. In 1961 Jaffee estimated that there were 167,000 such women in New York City. By canvassing all of the family planning facilities in

the area, he discovered that 17 such centers were serving roughly fifteen per cent of this medically indigent population. Thus eighty-five per cent of this population was not being served by the available facilities. In that kind of a context it really doesn't make much sense to talk about the social and psychological family factors that interfere with the use of contraception if the services aren't even available for the population you are concerned with. Yet from numerous research studies we have every reason to believe that a great majority of these potential users did not wish to be vulnerable to unplanned pregnancies and did desire birth control services.

In the five years between 1961 and 1966, New York City was able to increase the number of clinics from 17 to 69. By that year there were 69 municipal hospital clinics, 27 voluntary hospital clinics, 8 health department clinics, 2 anti-poverty clinics, and 16 Planned Parenthood centers. These centers, altogether, it was estimated were now serving fifty-one per cent of the medically indigent population instead of the fifteen per cent five years previously. Thus, though the number of clinics increased fourfold, none of them had any difficulty finding patients. Indeed, many of them had waiting lists. The clinics were widely dispersed throughout the city, and a great majority were established in or immediately adjacent to the major poverty areas of the city.

These clinics were not models of well-financed and carefully planned medical services. As Jaffee points out, the results are all the more remarkable in that "approximately half of the indicated population has been enrolled by programs which have been fundamentally understaffed, under-financed and uncoordinated. This provides impressive confirmation that the singlemost important strategic decision in planning for community needs is to establish free or subsidized services which are geographically accessible to the population in need." Such a shoestring operation means stretching resources to establish as many facilities as possible, even though in terms of staff these are operated on only a part-time, almost catch-as catch-can basis.

The results suggest that we should not concern ourselves with the special problems of the poor in connection with family planning, problems of motivation, disorganized lives which make the pursuit of a careful regimen difficult, and the like, until we are sure two things have been accomplished: First, that services are as widely available as is humanly possible, given the resources that can be found; and second, that maximum publicity about their availability (with heaviest reliance on word of mouth) has been given.

The emphasis on diffusing services means that there is maximum gain for the investment (a high benefit-cost ratio) because one serves first those among the medically indigent who are most ready to be served.

There are numerous administrative implications of this kind of strategy. After establishing as many centers as possible, the emphasis must be on efficient processing of the patients. Because the demand is initially much greater than can be met, every effort must be bent to providing services as quickly as possible and moving on to the next patient.

Some of the characteristics of professionalism in medicine, and I would assume also probably in social work, come very much to the fore because the notion of doing the best possible job often results in reducing the services that are actually available to people, because simply too much time is spent with individual patients. I was arguing with a physician who had been one of the pioneers in setting up one of these clinics because she insisted when a woman came in the door for family planning services, they had to give her a Pap test and several other things because that was the only chance they had to look after her health. Well, that is a very humanitarian point of view, but it is not really dealing with the need that this woman and all those other women in the line feel perhaps is most pressing. Their most pressing need is not to have another child, and the Pap test problem, and so on, while it makes good public health sense in one way, perhaps doesn't make as much sense given the tremendous lack of service in the family planning area. It is not as realistic from a point of view of the people as it seems from the point of view of the physician.

In addition, administrative simplicity in the delivery of supplies becomes very important. Any time that is wasted on re-supply of patients who have been served once subtracts from the time that is available to process new patients. Thus, there is ample room for creativity in discovering simpler methods of supplying patients once they have made their initial visit. Perhaps this could be done by mailing supplies, setting up sub-stations which dispense supplies to registered patients, transferring supplies in some way to private outlets, or encouraging the patients to purchase their supplies on the open market.

Our image of the medically indigent should not mislead us into believing that poor people will not buy contraceptive supplies once they are convinced of their desirability. Almost any poor woman will afford to spend \$1.50 a month on contraceptive pills once she is convinced that they will keep her from getting pregnant. It doesn't take a specialist to tell her that a new child costs more than a \$1.50 a month.

The main task of subsidized family planning services is to get patients started on contraception and to assist them over any initial difficulties. After that they can probably move back into the normal contraceptive market with a little help as to where to get their supplies most inexpensively.

We can assume, then, that very wide extension of family planning services will result in the diffusion of effective family planning to a large majority of low income families. When this has taken place, however, there is one kind of pregnancy limitation situation that is probably not really covered by wider extension of current family planning efforts. The great majority of those who avail themselves of family planning services are women who are married or who are living in regularized consensual unions. One of the effects of poverty, however, is to interfere with the regularized mating unions that we call marriage. Marriages are disrupted by poverty, so that one of the characteristics of poor areas is a high proportion of separated and divorced women, women who stay separated and divorced longer than their more fortunate sisters because of the difficulty of establishing a new marriage where

men are unemployed or earn poor and irregular incomes. In the same way, the lower class areas tend to generate peer group systems in which there is a high level of premarital sexual activity so that a relatively high proportion of girls become pregnant before marriage, and also a relatively high proportion of them actually have their babies before marriage.

Kingsley Davis has called the combination of the illegitimate birth rate and the premarital conception rate of those who subsequently marry before the birth of the child a "social tragedy conception rate." This rate is very high in lower class areas compared to working and middle class areas. To the extent that protection can be provided against the risk of conception in these circumstances, the gain for the individuals involved and for the society are probably even greater than those of protection against conception within marriage. Yet there are significant impediments to the provision of this kind of protection, both in the way services are organized and in the nature of the social and sexual relations that lead to pregnancy.

Family planning organizations have shown a great deal of reluctance to provide family planning services to unmarried women even though we see an increasing consensus that it is all right to provide such services to a woman once she has had an illegitimate birth. Girls who want to protect themselves for the first such birth, however, tend to be shunned by family planning organizations, even when their parents approve such protection.

Sooner or later family planning organizations are going to have to modify their prejudices in this regard and are going to have to devote as much thinking and energy to making family planning services realistically available to the unmarried as they do to making them available to the married. The situation of the girl who has not had her first child and that of the unmarried woman who has had at least one child are rather different, so let's consider them separately. In terms of the proportion of illegitimate births among the poor, and most particularly among Negroes, it is the women who have already had one child who account for the majority of illegitimate births. Thus in 1962, in sixty per cent of the cases of Negro illegitimate births, the mother had had at least one child previously. Obviously a very high proportion of these women are women who have been married and whose marriages are now broken. From the point of view of such a woman, the question of family planning is a rather ambiguous one. Few divorced and separated lower class women, even if they have a boy friend, think of themselves as engaging in regular sexual relations the way a married woman does. Rather, sexual relations occur on an irregular, relatively unplanned basis, for example, when the boy friend arrives unannounced for a visit. For many of these women, the taking of oral contraceptives hardly seems sensible. After all, they do not think of themselves as habitually engaging in sexual relations and, therefore, are not as likely to think of taking a pill every day to guard against that possibility. The chemical and mechanical contraceptives make even less sense, particularly where a woman is tense about sexual relations with a man who is not her husband. In this case the intrauterine device makes much more sense. Significant inroads on the family limitation problems of separated women are likely to be made only with methods that protect over long periods of time without the necessity to follow a daily routine of contraception.

The situation with pre-marital sexual relations is even more difficult from the point of view of effective protection. The unmarried lower class girl has even less reason to consider herself as engaged in sexual relations in any regular way. She has sexual relations less often and she tends not to think that because she has had intercourse with a boy once she will necessarily have it with him again. On the other hand, it is not at all uncommon for unmarried girls in the lower class to recognize that over a period of time, given their pattern of heterosexual activity, they are likely to become pregnant. On a very irregular basis they may attempt to practice contraception--foam, for example, is very popular in this set--but the methods they use do not approach effectiveness over a period of time. For this group, two methods are required, one which would provide long term protection from one treatment, as in the case of the IUD, or one still-to-be-developed psychological or chemical method, such as the morning after pill, or something like that.

To a considerable extent, then, the prospect for significant extension of services for the unmarried group probably depends on continued technological innovation. If, however, family planning services are organized to take into account the non-routine nature of sexual relations for them, and if the services are offered in a matter of fact and non-stigmatizing way, significant inroads can be made for women who already have one or more children and tend to think of themselves as somewhat more regularly engaged in sexual relations.

For the pre-marital situations, on the other hand, probably not a great deal can be done with present methods except for a family planning organization to relax their nervousness about dealing with girls who have never been pregnant and to serve them with the same matter of factness as they serve any other woman.

In short, the most significant way of facilitating the acceptance of family planning by a low income population is simply to disperse facilities as widely as possible in low income areas, and to operate those facilities with a minimum of red tape and or moralism about who is and who is not entitled to help, and with an eye to the rapid diffusion of technological innovations as they occur.

Family Planning: One Part of Comprehensive Maternal and Child Health Care

HELEN M. WALLACE, M.D., M.P.H.*

Introduction

Comprehensive care of mother and children, and of fathers as well, has as its main objectives assistance to families so that as nearly as possible optimal physical, emotional, and social well being may be achieved. It includes housing, food, income maintenance, education, vocational training and placement, as well as health and other social facets. Comprehensive care requires that staff give personal attention to every family member so that the individual needs of family members will be considered and met. Assisting families to enable them to decide upon the number of children they would like and to make it possible for them to achieve this goal is also an important part of comprehensive care. It is difficult to see how couples may reach optimal physical, emotional and social well being when they have many more children than they want and are able to provide with loving care and attention; or when they want children and are unable to have any. Thus, looked at broadly, family planning is merely one part of a total or comprehensive approach in working with families to try to help them. To separate or isolate it from the broader base of comprehensive care is to fragment care, so that the total needs of families may not be considered simultaneously and may not be met.

Medical and Health Facts as Basis of Need to Integrate Family Planning and Comprehensive Maternal and Child Health Services

Any public health program must be based upon sound medical and health data. Ignoring these facts in comprehensive maternal and child health (MCH) care is the equivalent in clinical medicine of treating superficial symptoms and not the underlying disease. In this section of the paper I will present some of the medical and health background information needed as a basis for integrating family planning and comprehensive MCH care.

Both maternal and child health and family planning are directly concerned with the health of the individual and the quality of family life, physical, social and emotional. Combining efforts, both MCH and family planning should have a better chance of strengthening family life and improving the quality of parental care in present society.

*Professor and Chairman, Division of Maternal and Child Health, University of California School of Public Health, Berkeley, California.

There is a direct relationship between the outcome of pregnancy and family planning. Only when fetal, infant, and childhood mortality are reduced and children survive will a family accept family planning. Thus, improvement of health services for mothers and children is a prerequisite for family planning. Child spacing itself is an important factor in the outcome of pregnancy. The longer the period between pregnancies, the lower the incidence of prematurity. An optimal interval between pregnancies (i.e. prevention of a rapid series of pregnancies), increases the possibility of reducing maternal, fetal, infant, and childhood mortality. Also, child spacing may be of assistance in decreasing the syndrome of maternal depletion. Child spacing will provide a better opportunity for the nurture of the individual child and thus a possibility for prevention or reduction of such complications as gastrointestinal infections and undernutrition during infancy and early childhood. It may help to improve the quality of family life and to raise the standard of living, by decreasing the number of dependents requiring intensive personal care, education, food, shelter, clothing, etc.

There is also a direct relationship between maternal mortality on the one hand, and gravidity, parity, and maternal age on the other. Thus, in the interest of prevention, family planning services need to be directed toward certain priority groups such as older women and the grand multipara.¹ At the other end of the maternal age scale, there is also a direct relationship between age and outcome of pregnancy; the younger the mother, the less favorable the outcome. The implications of this for school health and college health programs are discussed below.

One of the major causes of maternal mortality in the United States is illegal abortion which is a negative method of family planning. Thus, when family planning is not available or it fails, abortion may be resorted to. The entire abortion problem is in need of review--incidence, indications, circumstances, safety, outcome, supervision, and the social and legal aspects.

There are many couples with certain types of complications or history of reproductive failure who need family planning services as an integral part of their total medical and health care. These include those with certain genetic diseases, diabetes, toxemia, heart disease, repeated caesarean section, or those with a series of unfavorable outcomes of pregnancy in general.

Most of the present day methods of family planning in use require close medical and health supervision, evaluation, and review. Exact knowledge about a couple is necessary in order to guide them in the selection of the contraceptive method most appropriate for them. Basic minimum family planning standards should require a general health and social history and physical examination; a review of the menstrual and reproductive histories; a pelvic examination; and a Papanicolaou smear. Exact knowledge about the position and condition of the uterus is essential for the use of the intrauterine device (IUD). Relevant important problems are the side effects and complications of the contraceptive modality used. These include the symptomatic side effects of the pill or the IUD; lack of retention of the IUD, or uterine perforation with its use; and the need for discontinuance of any modality for cultural, health, social or symptomatic reasons. Medical and health

standards have recently been drawn up for the prescription of oral contraceptives.² These standards include the examinations (initial and follow-up), precautions, contraindications, and limitation of use. Similar standards are needed for all contraceptive methods.

Pregnancy may occur in women using any contraceptive method. Research is under way to determine the feasibility and efficacy of immediate postpartum contraception. More frequently, contraception has been prescribed at the time of the six week postpartum examination. These are also illustrations of the need to integrate family planning and maternal health services, from both a therapeutic and investigational point of view.

Care for girls and women of the child bearing age should be provided in a longitudinal way--preconceptional, antepartal, postpartal, and interconceptional. Both from the viewpoints of education and of actual service, family planning is related to every phase of maternal care. To remove one part of comprehensive care is to artificially separate and fragment it for the individual woman. Family planning may be so separated from the rest of maternity care that its potential availability and effectiveness become reduced.

An example of fragmentation occurred in a Maternity and Infant Care Project we visited recently. In it there were "maternity and infant care (MIC) sessions" two half days a week, and "family planning sessions" two half days a week, on different days. We asked what would happen if a nonpregnant woman presented herself on the day when an MIC session was held. We were told that she would be referred for a return visit for a family planning session which met several days later. We asked whether she could be seen during the MIC session, and were told "only if there was an emergency." Furthermore, the reverse of this was also true. A pregnant woman who first came to the Project on a day a family planning session was held was referred to the next MIC session, usually several days later. On the one hand, we are trying to promote the idea of comprehensive maternity care, and making family planning services available to all who want them; on the other hand we seem to devise systems of care which deter this.

Couples with infertility problems also need family planning programs, including such services as: 1) a general health history, including menstrual and reproductive history; 2) a social history; 3) a health evaluation; 4) a gynecologic and endocrinologic review of the woman; 5) review of the male's reproductive history and potential. In addition, counseling and referral to adoption agencies should be included.

It is evident from the foregoing illustrations that there are sound medical and health reasons to look upon family planning as an integral part of comprehensive maternal health care. To establish family planning separately from maternal health and from MCH may result in separating it from its appropriate medical and health base and from the necessary medical and health supervision and care.

The Need to Bring Services to the Target Population and to Reach Them Where They Are

One of the basic principles underlying the planning of any health service is to identify the target populations--who they are, where they are, and how they can be reached most easily, most effectively, and at least cost in terms of effort, time and money. If we apply this to the field of family planning, where our target populations include girls and boys and men and women of the child bearing age, we should look at where they already are, how they can be reached, and what the opportunities are to get to them as easily as possible. The general principle which should be followed is that wherever there is contact with families there is an opportunity to introduce family planning. Following are examples of the kinds of programs in which family planning information and services should be an integral part:

School and college health services.--Since one group of girls and boys of the child bearing age is in school, we should reach them through the channel of school health and college health services. Hence we can see that there needs to be incorporation of family life education, including sex education, into the school health and college health programs.

Premarital examinations.--Some states have a law requiring a premarital health examination. Usually this has been interpreted to mean that only a serological test for syphilis is required. Nevertheless the concept of the premarital health examination should be much broader. Hence, where there is a law requiring a premarital health examination, an opportunity exists to introduce family planning.

Maternal health services.--Another target group consists of pregnant women who are attending maternal health services. Hence, we can begin to introduce family planning education in existing prenatal clinics, delivery services, postpartum services, and MIC projects. An opportunity is available to integrate family planning into the total spectrum of maternal health services, and this opportunity needs to be used to the maximum. It has been the experience of many maternal health programs that postpartum clinics have been poorly attended by women. However, when family planning is added to the usual service, the percent return of women has risen from 10% who attend to 80-90%. This is an example in which the introduction of family planning strengthens an existing service.

Certain groups of women of the child bearing age especially are of high risk and hence are of higher priority when considering target populations for family planning services. These are women of "advanced age" (i.e. over 35 years) or of higher gravidity (having five or more pregnancies). Furthermore certain women who have unfavorable health and reproductive histories also represent a target group. They include women with heart disease, toxemia, diabetes, genetic diseases, or who have had repeated caesarean sections. These are examples of women who have higher maternal mortality rates, or whose pregnancies terminate in higher fetal or neonatal mortality rates, and hence need to be considered as candidates for family planning.

The concept of reaching the target population where they are can be extended to whoever provides maternal health services for women. In the United States this includes physicians, nurses and social workers. In this context it then means working to bring family planning knowledge to these professionals and trying to enlist their support and cooperation in bringing family planning knowledge and services to the people they serve.

Abortion services.--Still another part of a maternal health service where there is great need to introduce family planning, and where there is equally great opportunity to do so, is wherever women are cared for who have had an induced or suspected induced abortion. This represents a target group of high priority. They have already decided to limit the number of children they will have. They need help in learning how to do this in a safer way. Hence any hospital service caring for postabortal patients needs to have a closely integrated family planning program.

Services for unmarried pregnant girls.--There is great need to introduce family planning in any special service for unmarried pregnant girls. There is some evidence to indicate that a significant proportion of girls who are pregnant out of wedlock become repeaters of this pattern. Hence, even if it cannot be entirely prevented the first time, this is a target group who could be helped to prevent out of wedlock pregnancy for the future through the introduction of family planning during their pregnancy, or after their delivery.

Child health services.--Many women of the child bearing age take their infants and children back for health care. This service may be one for so-called well infants and children (such as a well baby clinic or child welfare clinic), or it may be for all children well or sick (such as a general pediatric clinic, a pediatric in-patient service of a hospital or a Children and Youth Project); or it could be a general immunization clinic which is largely attended by children and their mothers since it is women of the child bearing age who usually take their children. Thus, we can say that in any service for infants and children there is an opportunity to introduce family planning.

Head Start and day care programs.--Certain specialized services for children such as Head Start or day care programs, also provide an opportunity to reach families in which the parents are of the child bearing age. In such a setting their mothers will be present at some time and it may be opportune to introduce the question of family planning and to have family planning service easily and readily available.

Child welfare services.--Possible candidates for family planning are those families in which there is evidence or suspicion of the problem of child abuse, since, in one sense, this is a form of rejection of children. One might extend this further to say that abused children may be children who are basically unwanted. One implication is the need, insofar as possible, to prevent the birth of unwanted children. Other parents using or in need of child welfare services should also have family planning counseling immediately available.

Venereal disease services.--A venereal disease service represents another opportunity to reach one part of our target group. Since

venereal disease occurs in sexually active men and women, who are usually of the child bearing age, this provides an excellent setting in which to introduce family planning.

Tuberculosis services.--Households where there is a known active case of tuberculosis with a positive sputum represent a serious health hazard for infants and children as well as other members of the household. Hence to introduce new children into a setting like this is to immediately set up a chain of events which has long been recognized as dangerous to the health of children. Thus, family planning should be an essential part of a tuberculosis program.

Industrial hygiene programs.--In a similar way, the field of industrial hygiene and occupational health represents a channel and opportunity for the introduction of family planning. This field encompasses many men and women of the child bearing age and represents the part of the population who might be reached through their employment, either through their unions or at their places of work. The point is that they represent a population group relatively reachable and, undoubtedly, many of them are interested in family planning.

Services to handicapped children.--Couples who have had a handicapped child also represent an important target group. For example, they may decide to have no more children. Or they may have had a child with a genetic condition, and be of high risk of having more children with the same condition. I have heard it said, although I have seen no facts or studies to support this, that giving birth to a handicapped child (i.e. a child with a congenital malformation) is such a highly stressful situation that a pattern of much more frequent intercourse is developed during the immediate period of great stress. Hence there is thought to be increased chance of an early conception occurring. Services for handicapped children and their families need to consider the family planning aspects. Counseling in regard to family planning needs to be a readily available part of any service for handicapped children.

Mental health programs.--In terms of future child rearing, serious emotional disturbance in one or both partners hardly provides a favorable setting for conception to occur. Thus, the couple should be encouraged to consider pregnancy prevention until such time as psychotherapy has resulted in more favorable timing for a pregnancy. This means that hospitals and clinics, adult psychiatric services, alcoholic rehabilitation clinics, child guidance clinics, etc., and other community mental health programs should include a family planning component.

Mental retardation services.--I have heard parents of mentally retarded teenage boys and girls express their concern about the possibility of pregnancy occurring. Thus, family planning information and services need to be available to them in their various programs, such as special classes, day care, recreational programs, institutions, etc.

Other health services.--Still another way of incorporating family planning into MCH services is to do so at the point of contact with a family member wherever the contact is made. This may be done when the family member visits a health center or hospital, or when a health worker visits the family at home for any reason.

The Role of the Social Worker

A traditional role of the social worker has always been that of the family counselor, one of the people who provides supportive and counseling services to individuals and families in need. Certainly many opportunities obtain throughout the spectrum of existing health and social services for social workers to introduce the idea of family planning for those individuals and families where family planning service fits the situation at the moment. A review of many individual and family circumstances will undoubtedly reveal that family planning may be of interest and help.

For social workers knowledgeable about maternal and child health and family planning, another equally important role is promotion of referral to and use of community family planning services by staff members of related agencies. I am thinking specifically of the need to work closely with staffs of welfare departments to help them in their work with individuals. An example of this is women who are receiving Aid to Families with Dependent Children (AFDC). Other examples are working with the staffs of maternity homes, Head Start programs, day care centers, services for handicapped children, hospitals, mental health services, etc. Making information available to such staff members is an important contribution in helping them serve their own individuals and families better.

Summary

Family planning is one of the essential services for persons of child bearing age. It truly is a part of longitudinal comprehensive care of families from both the health and social points of view. If we as health workers are to be able to help families of high risk and high priority, then we need to be able to see and understand their needs as broadly as possible. To isolate one need and try to approach it in a separate way is to defeat the objective of helping families achieve optimal physical, social and emotional health and well-being.

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Cultural Perspectives on Family Planning Services: Panel Discussion

MAYHEW DERRYBERRY, Ph.D.* and FAUSTINA SOLIS, M.S.W.**

Dr. Derryberry

I am not going to talk about the ethnic and cultural aspects of family planning as they may occur to you. When we think about this topic, I believe most of us think in terms of "them." But I am going to talk about it in terms of the culture of the services we offer. In this regard, I think we are all mixed up. In fact, in its present form, I think family planning is almost a schizoid service. I would characterize it as one in which there are extremes of opinion about the various aspects and a minimum of valid data to substantiate the opinions. Let's look at some of these differences.

There are those who are highly optimistic (as Dr. Rainwater was this morning) about what can be done in family planning. But those who are active in the program find many difficulties that are not apparent on the surface. Then there are the Kingsley Davises here at the University who say family planning limited to contraceptive services will accomplish nothing.

In a document published by one of the drug houses that manufactures contraceptives, a director of family planning service is quoted as saying "the world of family planning is a simple area of activity."¹ A professor of internal medicine at a conference on Teaching Family Planning in Medical Schools stated that family planning is a very complicated area. Our ignorance of what to do and how to do it is appalling. We don't know enough about the social and behavioral aspects of family planning and population control. Mrs. Mednick in her presentation illustrated that we have a lot to learn.

There is confusion among various workers as to what we are trying to do. Family planning means quite different things to different people. We saw a little of this divergence this morning. Dr. Rainwater stressed that "family planning services are a part of

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comprehensive health," and Mrs. Mednick added "social services so that all families can have the number of children they want." This latter definition of goal stressed the need to give much more effective service to the productive women so that practically all pregnancies are protected. This definition of family planning could result in an increase rather than a reduction in the population.

At the other extreme are those who feel family planning services are for the purpose of reducing the rate of population growth. This is what Dean Reeves was intimating this morning when he listed for you the four priority subjects of his concern. His first priority is population, its growth and how to control it. This was also the meaning attached to family planning by a professor of medicine in Washington when he said "we as a nation eat too much, reproduce too much, and fight too much. We must learn to eat less, reproduce less and stop fighting." He went on to say "we cannot continue the basic right of a woman to reproduce as she sees fit." Others maintain there should be freedom of choice to have as many children as a family wants, which is certainly at the opposite end of the pole.

Some workers have planned a family planning program in a highly mechanistic fashion. Their claim is that, if there are efficient services conveniently located and offered at convenient hours for the clients, mass publicity is all that is needed to get people to practice family planning. Advertising sells cars, why not family planning? But how over television can one explain how to use a condom, fit a diaphragm, or what an IUD is and does? Too many programs, especially those overseas, are planned on a mechanistic assumption.

Many programs are planned by adopting procedures used in analogous programs without considering the behavioral differences involved. Let me give one illustration that came out of the meeting of the Association of Planned Parenthood Physicians. One physician drawing on her maternal and child health experience said "the best time to follow-up a client after her initial visit is immediately after the first missed appointment." This is a perfectly adequate and proper follow-up for pre-natal care. But if the method is either the pill or the IUD, it is not satisfactory for family planning. Any side effects occur almost immediately and what a woman learns from the side effects without support from the clinic can be very detrimental to her continued practice. It may also detract from future success of a program for a dissatisfied user can communicate her feelings to several of her neighbors and friends. The follow-up needs to be done at a time which will maintain the greatest satisfaction toward the service.

Oftentimes in our programming we do not recognize that family planning touches some of the most emotional and personal areas of our lives. They are concerns we often do not discuss even with our spouses, our brothers and sisters, let alone strangers. This was illustrated this morning in the comment that women find it difficult to discuss sex matters and family planning with their physicians, and doctors are hesitant to bring up the subject with their patients.

The educational procedures in many family planning programs have been developed on the principle of diffusion described in connection with the adoption of new agricultural practices. The principle

works somewhat as follows: an enterprising farmer learns of a new kind of wheat, corn, or rice or some new chemical that will increase his yield. His results are much better than his neighbor's who has not used the innovation. The outcomes are immediately apparent to his neighbors who ask about what he has done. In other words, there is immediate and direct communication between the innovator and his neighbors. As a result the idea diffuses through the farm population, first slowly and then with increasing speed of adoption. But is there the same amount of communication about such a private and sensitive subject as contraceptive practices? I don't know what women do, but the men with whom I associate don't talk about the kinds of contraception they use or whether they use any at all.

I was in India for three years working in the family planning program. All my Indian associates were devoting their professional efforts to family planning for population control. Yet in all that time only two Indian men mentioned in my presence the kind of contraceptive they used. One had a vasectomy and the other used the rhythm method. Only one U.S. associate has ever mentioned the kind of contraceptive he and his wife used. With such lack of communication between associates, I question the assumption that family planning practices will diffuse through a population.

Someone mentioned that the husband-wife relationship and the communication between them greatly influenced continued practice of family planning. Despite this passing reference to the importance of the husband, most of the discussion I have heard so far in this conference has centered on the woman. Only now and then were the men mentioned and even then in a minor way. Not enough attention in programming has been given to a man's role in assuring continued acceptance of the service.

In reporting progress on most programs, the assumption is made that if the clinics are full the program is successful. So long as there is a desire for service and a limited number of clinics, the clients will fill the clinics. But acceptance by clinic attendance a few times is not enough. Program success is dependent on continued practice. The period for this continued practice is for the fertile period allowing for the intervals during which a family has planned a pregnancy. Studies on the IUD show that 50 per cent of them are out in 18 months to two years. A state director of family planning stated that 30 to 50 per cent of the women for whom he prescribed pills discontinued their use within six months. Other recent studies show that one-third of the American women who say they do not intend to have any more children admit they have already had one unwanted child. One-half of those who report they did want their last child, reported a failure in having it at the time they wanted it.

This recitation of divergencies in opinion and deficiencies in programming is designed to emphasize that family planning is a complicated service and one that is not meeting the need in many cases. Yet far too often it is treated as a simple program.

Let me mention one or two more peculiarities. I know of no program that advises as many methods (treatments) to achieve its objectives. For a woman there is the pill, the IUD, diaphragm, foams,

sterilization, and abstinence. For a man there is the condom, abstinence and sterilization. Our educational program states that the client can take his choice. But does he or she know enough to decide without far more assistance in thinking it through than is now given?

Dr. Rainwater mentioned in his talk that it only takes two or three minutes to give family planning advice. Maybe that is true for a well-informed person who already knows about family planning and something about the methods. But if adequate instruction is going to be given about the different methods and how to use each, it will take much more than a few minutes.

Sex education as an aspect of family planning is another controversial area. Mrs. Mednick described a successful program in which it was an integrated part of the school health education program; Dr. Rainwater suggested that it could and should be given in a couple or at most three lessons. Then there are those who maintain it doesn't belong in the educational program at all.

There is disagreement on how to deal with the sexually active unwed girl. Some maintain she should be protected from a pregnancy that may be very devastating to her future. Others will only provide information and services after she has had at least one pregnancy. In this connection, I should like to describe the service developed by Dr. Pion of Washington. In his university medical school clinic he provides a pregnancy testing service for anyone who comes in and requests it. Among those with a positive test are some who wanted to be pregnant. These girls are referred to pre-natal care service. Others who are pregnant and did not want to be are candidates for a "crisis intervention" service. Those who are negative and did not want to be pregnant are referred for contraceptive services and those who wanted to be pregnant and were not are referred to fertility services. It is this systematic way of approaching family planning that is so badly needed in all phases of the program.

My purpose in presenting these differences of opinion and divergencies in program has been to alert us to the need for much more objective evidence upon which to conduct effective programs and to warn against too superficial analyses of all the factors that are involved.

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Miss Solis

Dr. Derryberry discussed the culture of family planning services. I would like to bring some of his comments into the arena of our direct work with people. He expressed great concern about the schizophrenic pattern of services. I believe we can relate this to

the kinds of confusions that patients and consumers must have as a result of our own schizophrenic orientation.

There is no question about the fact that as providers of services we have developed our own special self-interest in the development and promotion of services, whether it be an individual self-interest or an agency self-interest. Some patterns that have developed in family planning are particularly open to question. As Director of a program that is geared for a population group in the low income range, I am faced oftentimes in budget negotiations and program evaluation with the following kind of reaction. When the staff of a particular health agency, for example a health department, wish to convince me of the effectiveness of their program, they tell me, "we are including family planning." Family planning is not a panacea for the health needs of people. Likewise, I think we have assumed that having Aide programs is the answer to manpower needs. We tend to assign special importance to a single program element that many times operates on a single channel to the exclusion of the totality of programming.

I get a little bit tired of talking about ethnic and cultural patterns and about their relationships to programs. It is beginning to sound like a very scratchy record. How has knowledge of cultural values actually been applied to the way that programs are planned or developed? The easy way has been to hire an aide on whom we place all the responsibility (even though we don't say so) of resolving the communication problems. Unless an aide is accepted for his competence in relaying ideas that will assist in the incorporation of new knowledge, I wonder if the aide oftentimes does not intensify the barrier that existed originally.

Many of the family planning programs in California are directed to areas where there is a predominance of Mexicans or people of a Spanish-speaking descent, a culture that, from its inception, has had great emphasis on the role of a woman as a creator of life. To introduce family planning with merely the concept that having fewer children will make available for them a better and richer environment will not help a woman and her husband to resolve their feelings about this basic mission.

Another problem which concerns me is when I see forty or so patients attending a family planning service in one evening. I always want to know what was the quality of service and counseling that was given. Family planning can mean anything from a distribution center to a complex outreach program where follow-up is not just to determine the use or lack of use of contraceptives. Rather great consideration is given to the total psycho-social impact they have made on this individual, on this couple, on the total family.

Yesterday, I met with a group of teachers and young people, none older than eighteen, who are aides in a migrant education program. I had been advised by the faculty that they might not want me to speak because they had been very angry and upset about the way the program had been developed and they were really going to give it to whatever adult was directing the program. Most of these young people were of Mexican descent. When it came to the point where they wanted to test me, do you know what question they asked me? They asked what I thought

about family planning and whether I believed that sex education should be in the schools. These were their points of attack. They were testing whether I would deny their culture or not. But the most important thing in all of this was the discussion that ensued about what family planning is from the point of view of emerging youth. We agreed this is a very important area which is not as simple as an outline in a project proposal. We raised questions about where do we start with it and how do we start with it. If we start with child care we think we have to start when a young woman has had her baby and not before that time. In this particular culture where people have been taking care of young children since they themselves were the age of six, isn't it ridiculous that we start teaching them child care only when they have their own first baby? Likewise, when they have been facing the kinds of deprivation that result from many siblings and tired and worried parents, why do we wait until the cycle starts for them? I am throwing this out to you because you really are concerned about family planning and the broadness of the problem. In program planning there must be some foundation of reality, and it is this reality as they define it that is the cultural component of any particular population group.

It has been many years since I was a student in a school of social work, but I remember a course that was involved with studying our own culture and its relation to the idiosyncrasies of our demands. I wonder if we really do have this kind of understanding. It doesn't have to be based only on another ethnic group; it can be based on the complexity of social, economic and political life of any group and how this relates to a program and its development.

We have seen that in some health programs in rural areas, where no other kind of direct health service is provided, one of the major preventive services that is considered for the area is family planning. Is there any wonder that some of the population consider this genocide? We may not have programs to take care of the hazards of working in the field, but we sure have family planning. We don't have anything to take care of acute illness of people, but we do have family planning. When we say that our mission is to meet the health needs of people, and that this is our responsibility, is this an honest statement in the light of our programming and delivery systems?

Medical Aspects of Family Planning

SADJA GOLDSMITH, M.D.*

The pill is the method of greatest interest and concern to most people in the United States because there are some 8 to 9 million women in this country who are currently on the birth control pill, a potent medication taken daily by healthy young people. The pill's popularity is ascribed to its efficacy, simplicity of use, and its effectiveness--it is virtually 100% effective. Another important consideration is that its use does not interfere in any way with the act of intercourse.

Basically, the pill is made up of estrogen and progesterone, two sex hormones which are ordinarily made in a woman's ovaries. There are two synthetic estrogens that are used in different pills and ten or more synthetic progesterones. The various combinations of these two hormones in different dosages give the pills their slightly dissimilar properties. Basically, however, most birth control pills on the market today are very similar in action despite different names and packaging.

Just a word about the history of the pill. It is an intriguing history. It has been known since the 1930's that estrogen and progesterone, if taken orally or by injection, will prevent ovulation and therefore prevent pregnancy. However, not much was done about this knowledge until the early 1950's, when the enormity of the population problem was beginning to dawn on researchers and others. At that time a major research effort was made to get an oral medication with few side effects.

When the pill was first introduced, the recommended dosage was about ten times higher than subsequently was found necessary to prevent pregnancy. The mechanism of action of the pill for the purposes of preventing pregnancy is simple to understand. The pill stops a woman from ovulating; it blocks her ovaries from putting out an egg. And if she doesn't put out an egg, she never has a fertile period: no egg, no pregnancy. The pill acts on the ovary and it also acts on the pituitary gland, which is the triggering gland for the fertility cycle. It also acts in various ways on many other organ systems of the body. The side effects which it may produce from these actions are under continuous evaluation by researchers. Because the pill is clearly a powerful medication with many physiologic actions, it is important that women take the pill under a doctor's direction. They should have a full gynecological examination and hopefully a total physical examination before they start the pill, and they should return for periodic checkups by their physician every six to twelve months.

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The side effects of pills have been much discussed in popular as well as medical literature. Among the annoying but not necessarily harmful side effects are: possible nausea when a woman first starts the pill; a certain amount of weight gain, breast fullness and tenderness, and occasional skin changes. Headaches if mild are sometimes just an annoying symptom, but if severe, should immediately be called to medical attention because this may be a forewarning of serious complications. Depression and emotional side effects are also occasionally seen. There is still a good deal of controversy about these emotional side effects, whether they are physiologic or whether they are due to psychological factors related to the complete efficacy of the pill.

The more serious question of the pill's possible side effects concerns various life threatening conditions. For example, are the pills causally related to cancer of the uterus, cervix or the breasts? Most medical clinicians think they are not. On the other hand, there is some indirect evidence on laboratory animals that estrogen may be cancer producing under certain conditions. However, this evidence cannot be transposed directly to man. The principal difficulty in studying this problem in humans is the long latent period for the development of cancer in man. Scientists looking at this question feel that the potential cancer producing effect of the pill can neither be affirmed nor excluded at this time. A major research effort must be made to clarify the problem, and is underway. One hopeful aspect in the cancer picture is that pill programs have resulted in better cancer screening for many women who would not otherwise have a yearly Pap smear and pelvic exam. Early detection of cell changes in the cervix can result in complete cure.

The second major issue that has been raised by the pill is that of spontaneous blood clotting or thromboembolism. This question has been raised by studies in England and case records here in the United States. Do the pills cause spontaneous clotting in the blood vessels with movement of the clot into the lung?

It has been very difficult for researchers to answer this question. Blood clotting and venous inflammation can occur in a number of other situations and also spontaneously with no known cause. Studies have been carried on in the U.S. and England to compare the amount of blood clotting that occurs in women taking the pill to spontaneous clotting. The question has been exceedingly complex, and sophisticated epidemiologic techniques have been used to elucidate the answers. At present there is evidence that these studies do establish a cause and effect relationship between thromboembolic disorders and the use of oral contraceptives. The mortality from thromboembolic disorders attributable to the pill is believed to be about three deaths per 100,000 women per year. For purposes of comparison, this risk is about comparable to the risk of death to a woman using an intrauterine device, from complications of infection or perforation.

This degree of risk may sound high or low to you. In thinking about it, you must balance the risk of the pill against the risk of death if a woman is not taking the pill. For example, if you take 100,000 women who are on the pill, there may be three excess deaths due to thromboembolism per year. If you take the same number of women using a less effective contraceptive method or no method, a sizable

percent of them will become pregnant within a year. The risk of death from pregnancy must be balanced against the risk of the pill. It is considerably more risky to become pregnant than to take the pill from a statistical viewpoint. In this whole reproductive field, nothing is quite as safe as abstention. If you totally renounce intercourse (from a statistical viewpoint!) you may avoid a good deal of trouble. You may, however, have other problems...

Another question that has been raised about the pill concerns future fertility. Will fertility be enhanced or impaired when a woman has stopped taking the pill? When the pill was first introduced, there was a good deal of talk, all of which was inaccurate, about possible superfertility after stopping the pill. A woman is generally as fertile after she has taken the pill as she was before she started, except that she is a few years older and fertility declines with age.

This is important for you to remember in working with your clients. A large number of women on the pill take it very erratically: on for awhile, off for awhile. And in the period they are off it, the likelihood of pregnancy is considerable. If a woman stops the pill, she is quite likely to get pregnant unless she substitutes another method in the interval.

What about the question of impaired fertility? Is the pill going to do anything to prevent a woman from having a family after she stops it? A number of research studies have recently shown that there is a small percentage of women who have difficulty in resuming their normal ovulatory pattern after they stop the pill. However, most of these women can be helped to start ovulating again if they go to a gynecologist for special treatment. Because of concern over this problem, many doctors are now recommending that a woman who wants more children discontinue the pill for several months every two or three years, in order to re-establish her normal ovulatory cycle.

I would like to review with you the different types of pills. So far, I have been talking about the combination pill in which estrogen and progesterone are present in all the 20 or 21 pills. There is another kind of pill, the so-called sequential pill. In this formulation, estrogen alone is given for the first two weeks and then the combination of estrogen and progesterone is given for the last week. These sequential pills have been considered more physiologic since they mimic more closely the normal body processes. They are useful for some women with certain side effects on the combination pills. However, a drawback of the sequential pills is that they are less effective than the combination pills. An occasional pregnancy can occur on the sequential, especially if a pill is omitted. Regularity in pill taking is thus even more important.

Many of you have heard of something called "mini-pill." This is an exciting new development, a very low-dose pill which is taken daily and which contains only progesterone. It is a very significant development because it usually does not prevent a woman from ovulating; its contraceptive effects are due to less drastic physical changes. It is believed to act selectively on the cervical mucus, making it more impenetrable to sperm, and also on the lining of the uterus to prevent the egg from growing there. It is significant that the

mini-pill contains no estrogen, the hormone probably implicated in the more serious side effects of the present pill. The mini-pill is something like 97% effective, with occasional pregnancies possible. The mini-pill is not as yet on the market for general use. It is being used in clinical trial pending Food and Drug Administration (FDA) approval.

There is a once-a-month pill which is now in field trial in Mexico. This pill has estrogen and progesterone in a long-acting formulation, and it is a pill that women may only have to take once a month. Such a method holds great promise for developing countries with low literacy. You can picture everybody taking her pill at some synchronized time, such as the full moon.

The "morning after pill" has received a good deal of press in the past year. This is a medication that women can take after intercourse to block pregnancy. For example, if a woman unexpectedly has intercourse without contraceptives during her fertile time, and if she rushes to the doctor the next day, he may give her high doses of estrogen to prevent pregnancy. This high dose, if started within 48 hours after her exposed intercourse and taken for five days, will block a pregnancy from beginning. It is clear that such a medicine could be most useful for women who have been raped or women who have had unexpected intercourse and are frightened of pregnancy.

But there are a variety of reasons why the morning after pill is not desirable for regular use. For one thing, for many couples a morning after pill would still be more or less a daily dose! Secondly, the high dose of estrogen can cause considerable side effects in many women--irregular bleeding, nausea and other potential hazards. So for these reasons, it is useful only as an occasional method. But when it is needed, it is very useful indeed.

Is there yet a pill that may be taken when a woman is waiting for her menstrual period, finds herself overdue and suspects she may be pregnant? There has been a good deal written recently about a pill that could dissolve an early pregnancy and actually be an oral abortion producing compound. However, no such medication is yet perfected despite continuing research in several countries. Such oral compounds are being tested, but so far they have been shown to be somewhat toxic and not consistently effective. It may take several more years before an oral abortion pill is ready for use. When such a pill is available, the controversy surrounding legalized abortion may be outdated. What you should carry away from this discussion now, however, is that there is no way at present to bring on an abortion by a pill or injection. The only way to interrupt a pregnancy, once it is started, is by a surgical procedure.

The intrauterine device (IUD) has a long history of use in man and animals. It has long been known that placing something in the uterus will prevent pregnancy, but the mechanism of action of the intrauterine device is not yet known. The intrauterine device is a small appliance made out of plastic or stainless steel. It comes at present in many shapes and sizes, and new types of IUD's are under intensive research.

How effective are these devices? If they are retained by a woman they are between 95 and 98 percent effective. Older women who have borne more children have a lower pregnancy rate with the IUD than younger women with less children. The main problems with the IUD are expulsion and removal. Because of spontaneous expulsion, or because of removal for side effects of bleeding and cramping, it has been found in field studies throughout the world that after three years only about 50% of women still retain their IUD's. However, with programs of contraception using the oral contraceptive, the same rather low continuation rates are found.

What about the safety of the IUD? It has been found to be approximately as safe as the oral contraceptive. There is an occasional serious problem due to the flare-up of pre-existing infection or due to perforation of the uterus. One unfortunate feature of the IUD is that it is not particularly good in women who have not yet had a pregnancy. In such women, insertion is more difficult and more uncomfortable and expulsion is more likely. This may be rectified as new types of devices are perfected.

The IUD is widely used in some developing countries because of its low cost and relative simplicity. Here in the United States it has been found to be useful for certain kinds of women. For example, it is a useful method for women who can't remember to take a daily pill, women who don't want to alter their systems with a hormone and yet want a method that doesn't require any action at the time of intercourse, or women who have infrequent, unexpected but nevertheless recurrent intercourse, which probably does describe a great number of people.

Is there anything new to say about the condom or rubber that a man uses? Theoretically, it's an excellent method with approximately 95 percent effectiveness. However, in the age of the pill, it is rapidly losing whatever popularity it once enjoyed. Back in my college days, we used to make condom counts when strolling along the riverbank in the morning, and never failed to find five or ten. Now you very rarely see them around. The people that are unhappy about this sign of the times are public health workers in venereal disease control. They feel the decreased use of the condom may be one of the factors associated with the rapidly increasing amount of gonorrhea, especially in the teenage and young adult community.

I think the condom should be emphasized as an interim method. No prescription is needed; it is sold at any drugstore. Some states, however, prohibit the sale of condoms to minors - a curious prohibition in view of high rates of venereal disease and out-of-wedlock births among teenagers.

In connection with commonly used male methods, a word about withdrawal, or coitus interruptus. Before reaching a climax, the man withdraws from the woman's vagina so that semen never gets into the vagina at all. This method is extremely widely used, especially among young couples who may lack access to other contraceptives. Withdrawal is a method which may produce anxiety in both partners and also may inhibit the female from full sexual response. However, it should also

be remembered as an interim method when nothing else is at hand since its efficacy in preventing pregnancy is quite high.

Just a brief word about the diaphragm and jelly. Many of us today are products of the diaphragm generation. Although it is not 100% effective, it is still a very good method which is now enjoying a kind of renaissance as women discontinue the pill due to fears of side effects. The diaphragm is about as effective as the condom if used every time, that is to say, about 95% effective. It should be remembered that consistent use of the diaphragm takes motivation at the time of intercourse on the part of the woman and the man. Both partners must cooperate to help the woman get up and put the diaphragm in if it is to be used consistently.

The vaginal foams or jellies, used without a diaphragm, are widely used today. They have the advantage of being cheap and easily available without prescription. The drawback of these methods, of course, is that they aren't as effective as the cream or jelly used with the diaphragm. They are only about 80 or 85 percent effective in most studies.

The injectable contraceptive is a method we are going to be hearing about in the next few years. This method has not yet received FDA approval for marketing, but is being used in clinical trial pending approval. The injection contains similar hormones to those present in the birth control pills. Instead of being taken daily by mouth, the compound is given in injectable form. The compound is then absorbed slowly from the site of injection and, depending on the dose given, can be effective from one to six months or more. The return of fertility after this time may be delayed, which makes it a better method for women who want no more children than for those who are merely delaying a pregnancy.

There are certain groups in the United States for whom the injectable would be an excellent method - for example, patients recently released from a mental hospital who want 100 percent protection against pregnancy but cannot be sure they will take a daily pill. Mental retardates are another group who might benefit from the injectable contraceptive, if permanent sterilization is not wished by the patient or her guardian.

In the future, a method of even longer term efficacy will be the contraceptive implant, a porous capsule which will be implanted under the skin of the thigh or hip by an injection technique. A contraceptive hormone will be slowly released from this implant which may prevent pregnancy for several years. The method will be reversible if the capsule is removed. Research on such a contraceptive is presently underway.

Two other methods of birth control are extremely widely used, but often are not considered as "family planning" methods because of traditional taboos - induced abortion and sterilization. Transition from the usual contraceptive methods to abortion and sterilization is most easily made by a consideration of the risks of contraceptive failure. Even with modern methods and motivated couples, pregnancy

can occur quite frequently, as documented recently in an interesting article entitled "A Mathematical Model Study of Contraceptive Efficiency and Unplanned Pregnancies." In this study, a computer was used to calculate the risk of pregnancy with 95 percent effective methods (the diaphragm and condom) and 99 percent effective methods (the pill and IUD) projected over a woman's reproductive years. It was assumed that women marry at age 20 and want three children, after which they become consistent contraceptive users. Considering the mathematical probabilities of pregnancy risk, it was found that if 100 couples relied on a contraceptive 95% effective after reaching a desired family size of three children, over 80 of them would have more children during their remaining 12 to 15 year period of fertile marriage. About three to six of these couples would end up with seven children. If a 99 percent effective method was used, about 30 of these couples would end up with more children than planned. This study gives credibility to what we have all seen. No matter how careful a couple is, women do have unplanned pregnancies. The computer's results are even more striking when you consider that they are based on consistent use of a method; not the lower use-effectiveness which is derived from such human foibles as women running out of pills, giving them up due to side effects, leaving the diaphragm under the bed, and so on. So it is obvious that even with the best of modern contraceptives, pregnancy will occur at times when it is unplanned and unwanted. Sterilization and abortion are therefore frequently requested and used to prevent unwanted children. (Reference for the above article, American Journal of Obstetrics and Gynecology, Vol. 104, No. 3, pp. 443-447.)

Sterilization is an operation that can be performed either on men or women to prevent future fertility. As you know, such an operation is not castration. The sex organs of a man or a woman are not removed in a sterilizing operation. However, I can assure you that many of your clients do not know this. They are frightened by the concept of sterilization, and they do not know exactly what the term means. The word itself has a frightening connotation and should probably be abandoned. Instead you can say vasectomy for the male operation and tubal ligation for the female operation.

Vasectomy for the male is a relatively minor outpatient procedure. What the doctor does is remove a small section of the tubes that lead from the testicles to the penis, through which the sperm travels. When the tubes are divided, sperm can no longer leave the testicles. The doctor performs this operation through two small incisions at the top of the scrotum, and it is generally done under local anesthesia. After this surgery the male is the same male that he was before. He has the same sex drive: the sex act is the same; the semen that comes out when he ejaculates appears the same. The only difference is that there are no sperm in the ejaculated fluid, so that he cannot make a woman pregnant.

Since a vasectomy operation often takes place in a doctor's office rather than in a hospital, the decision to perform it usually rests with the man and his doctor. Doctors vary in their thinking and practice in performing vasectomies. The operation is generally performed by a urologist, a surgeon, or a general practitioner with experience in this procedure. The operation usually costs between \$75 and \$150. Those of you from California know that if the man is

eligible for Medi-Cal (otherwise known as Medicaid or Title 19 coverage), Medi-Cal does pay for this operation. It is also possible to obtain financial assistance from an organization called the Association for Voluntary Sterilization, Inc., 14 West 40th St., New York, N.Y. 10018.

The operation of tubal ligation on a woman is more difficult because it requires an incision into a woman's abdominal cavity. It is usually done after childbirth, but is possible at other times. During the operation a portion of a woman's tubes are cut and removed. Her ovaries are left intact and functioning, so that she is not defeminized by the operation. She still has her menstrual periods afterwards. She still has the same sex drive that she had before. The only difference is that she is unable to get pregnant afterwards.

Hospital committees must pass on tubal ligation. In the past, hospitals have used guidelines based on a woman's age and the number of pregnancies she has had. At present, many hospitals are liberalizing their practices in this matter. If a woman has medical reasons for avoiding any future pregnancy, sterilization will generally be allowed. If she wants the operation to limit her family size, she may obtain it at some hospitals after the birth of two or three living children. Her age, emotional stability and life situation are all taken into consideration. Some hospitals have become increasingly liberal in the field of female sterilization in recent years. A recent California Supreme Court decision has stated clearly that voluntary sterilization is entirely legal in California, at county, as well as private hospitals.

Sterilization operations on men and women are generally difficult and sometimes impossible to reverse. Therefore, a man or woman who wishes the operation should be firm and comfortable about the decision. When this is so, psychological side effects are generally positive.

No discussion of birth control methods should omit induced abortion, which is a widely-used method in every known human society. Here in California, it is estimated that 100,000 women per year obtain abortions. Under the new liberalized abortion law in California, 4 percent of these abortions were legal in 1968 and about 10 percent in 1969. Legal termination of pregnancy, in a hospital setting, is a safe and relatively simple procedure. The medical risk of abortion in the first trimester of pregnancy is only one-tenth as great as the risk of carrying a pregnancy to term. In other words, medical abortion is a very safe procedure when it is done early. Psychological aftereffects seem to depend on the individual woman and the social setting in which the abortion is performed. Many recent studies attest to the fact that most women cope very well psychologically with the abortion situation.

However, the vast majority of United States abortions are still done illegally. Some abortionists are very skillful and others present tremendous hazards to the pregnant woman. An illegal operator cannot be equipped to cope with the occasional life-threatening results of uterine perforation, hemorrhage, infection, or anesthetic problems. Hopefully, illegal abortion may decrease as legal abortion becomes

more available. A meaningful decrease in illegal abortion, however, is unlikely as long as any legal restrictions on abortion remain. An interesting discussion of many aspects of the abortion issue is found in a book entitled The Case for Legalized Abortion Now, edited by Dr. Alan Guttmacher, published by the Diablo Press, San Francisco, California, 1967.

Social workers in states which have liberalized abortion acts should acquaint themselves with the Provision in California; for example, under the Therapeutic Abortion Act, a woman is eligible for an abortion if she is under 15, a victim of rape or incest, or if her mental or physical health is threatened by the pregnancy. Doctors and hospitals in different parts of California have interpreted the law more or less liberally. Doctors in the San Francisco Bay Area are performing many more abortions under the new law than are their colleagues in the Los Angeles area. Many abortion reform organizations are trying to advance the use of the new law while working for its further liberalization or repeal. If you wish further information, or help for a client with an unwanted pregnancy, you should contact any of the Planned Parenthood centers.

Many other states have passed or are considering abortion reform legislation. In the new climate of greater civil rights and sexual freedom for women, and concern over population problems, many state legislatures and courts are changing the restrictive and probably unconstitutional abortion laws of a previous era. The news-letter of the Association for the Study of Abortion, 120 W 57th Street, New York City, N.Y., 10019, is an excellent source for current information on abortion law reform.

A closing comment. All the present methods of birth control have their drawbacks, and yet there are many good methods available. Your clients deserve the fullest information so that they can make up their own minds about what to do on this matter. Studies show that an overwhelming majority of women would like their doctor or social worker to initiate the subject of birth control if this is done in a tactful and permissive way. I hope that the information given here will be helpful in enabling you to bring up the subject with confidence.

I would like to suggest some interesting publications in the field of birth control and population problems. Keeping up with the latest medical research aspects may not be as relevant to you as the translation of family planning know-how into social programs. For this, as well as for a survey of the social and ecological aspects of population growth, I will suggest a few publications which come regularly at minimal costs. Population Bulletin, put out by the Population Reference Bureau, deals with the problems of population growth on a world-wide basis in an interesting and readable manner. Ecology, sociology and cultural aspects of family planning problems are considered. (Population Reference Bureau, Inc., 1755 Massachusetts Avenue, N.W., Washington, D.C., 20036.) Planned Parenthood Report is a newsletter on family planning programs which will help you keep up with developments in United States governmental and voluntary agencies (Planned Parenthood Report, Planned Parenthood-World Population, 515 Madison Avenue, New York, New York 10022). International Planned Parenthood

News, which is published monthly in London, reports on family planning conferences and programs throughout the world. (IPPF News, 18-20 Lower Regent Street, London S.W. 1, England.) And finally, for those who want a more thorough treatment of world-wide family planning developments, there is Studies in Family Planning, published by the Population Council, which is available free of charge and comes out about six times a year with some fascinating and detailed essays in the field. (Studies in Family Planning, The Population Council, 245 Park Avenue, New York, New York 10017.)

Psychologic, Behavioral and Cultural Aspects of Oral Contraception

EDWIN M. GOLD, M.D.*

In less than a decade, the "Pill" has become not only the most popular drug since penicillin, but also the most controversial fertility control development of the twentieth century. As of now, between seven and nine million American females of childbearing age are aficionados. If we guesstimate global usage, probably eighteen million women are users. These are essentially healthy women taking potent hormonal steroids, not really as medication, but as a pharmaceutical convenience.

The burgeoning utilization of oral contraception has been referred to in a recent Journal of the American Medical Association (JAMA) editorial as "The Pill's Grim (?) Progress"¹ and it is a particularly serious matter to the clinician. They made the point that the contraceptive pill is unlike any other drug a physician prescribes. It casts him in the unfamiliar role of preventing a natural creative process rather than a disease. He no longer holds center stage. The patient has the initiative abetted by exponents of religious teachings, ethical precepts, sociologic principles and economic law. Last year The Committee on Public Education of the American College of Obstetricians and Gynecologists (ACOG) polled its membership relating to their contraception experiences. Ninety per cent of 8500 questionnaires were returned. In reply to a query as to which family planning method is most frequently requested by patients, 95.8% of the respondents listed oral contraception. This strongly suggests that women have made up their minds to ask for the "Pill" before they go to a doctor, and that the doctor obliges.²

Since Pincus and Rock established the efficacy of the oral gestagens a plethora of reports have emerged relating to clinical side effects. Siegal and Corfman³ have pointed out the need for massive epidemiologic studies to determine definitively the long-term medical side effects of oral contraceptives. These authors point out four major areas of concern as to potential adverse side effects. First, the potential effect on the vascular system and blood coagulation. Second, the possible relationship between oral contraceptives and carcinoma. Third, the potential development of certain metabolic diseases, such as diabetes. Fourth, the possible relationship between oral contraceptives and the occurrence of congenital malformation in

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children conceived during or after cessation of medication. In addition, practically every organ system has been involved in clinical reports on side effects. Yet, precious little in the way of controlled studies on the relationship of oral contraceptives to psychological and emotional reactions, sexual behavior and central nervous system activity have been developed, and in fact are almost totally lacking. The World Health Organization (WHO) Scientific Group recognizes that the usefulness of oral methods of fertility control depends on acceptability, effectiveness and safety. Not only medical, but psychological and sociological factors are involved and must be investigated.⁴

What do we know about the relationship of sex steroids to human behavior? Cyclic changes in mood and personality are clinically evident throughout the menstrual cycle. Mood depression, headache and irritability have been noted premenstrually. The incidence of crimes of violence, accidents, suicides and mental hospital admissions have been correlated with the premenstruum and beginning of menstrual flow. These behavior changes have been ascribed to fluctuations and declines in hormonal balance. Wallach and Garcia,⁵ quote the extensive studies of Benedek and Rubinstein correlating cycle phase with psychodynamic activity. The estrogenic phase was associated with heterosexual activity and increasing drive. The progestational phase was associated with narcissistic attitudes, passivity, receptivity and unconscious thoughts of motherliness. On the other hand, Pierson and Lockhart⁶ reported no significant effect of cycle phase on reaction and movement times in a group of college women. Accident-proneness, clumsiness, and lessened efficiency, traits frequently observed in the premenstrual and menstrual phases of the cycle, were attributed by these authors to inattentiveness secondary to menstrual discomfort rather than to direct hormonal physiologic effect.

Kane,⁷ in an excellent review article on psychiatric reaction to oral contraceptives, calls attention to a number of current biochemical research developments. He cites fascinating and provocative animal experiment evidence from a number of investigators, that mechanisms underlying sexual and reproductive processes, in the species studied, are intimately bound up with the function of the biogenic amines. He quotes Meyerson as showing that estrogen plus monoamine oxidase inhibitors (MAOI) inhibited sexual behavior. Increased MAOI levels produced decreased sexual response, while decreased MAOI levels increased the heat response. While the presence of estrogen was necessary to elicit this response, it is also suggested that progesterone may act by altering amine levels in brain or receptor response to amines in some way. Serotonin may also be involved. Serotonin has been shown to be a precursor of melatonin, a neurohormone of pineal origin with importance for regulation of sexual behavior. Estrogen has been shown to depress the enzyme responsible for conversion of serotonin to melatonin. The experiments cited, plus others indicating altered autonomic response with the use of gonadal hormones seem to indicate that emotional disturbance in a certain number of people using these hormones, should be an expectation rather than a surprise.

Another controversial area referred to by Kane is that of the rise in corticosteroids seen with use of the sex hormones. Thus a relative state of hypercorticism may exist in some of these patients.

There is then the possibility that the patient who develops psychotic manifestations on withdrawal of Enovid may indeed be suffering acute cortisone withdrawal symptoms.

Clinical reports on psychologic side effects of the pill, whether estrogen alone, combined or sequential estrogen-progesterone, or progesterone alone seem to resolve into two major areas. First, are mood and emotional changes ranging from anxiety, depression, tearfulness, irritability, nervousness, lethargy, disinterest in environment, guilt and actual psychosis to mood elevation and increased well being. Second, are sexual behavior changes including libido, frequency of coitus, and mutual sexual satisfaction.

In the ACOG Survey previously referred to,² personality changes were encountered in their patients by 37% of the physicians, decreased libido by 24% and increased libido by 21%.

Let's first consider the mood and emotional changes. Murawski and his colleagues⁸ investigated incidence and severity of mood changes in 80 married women (30 at the Boston Lying-in and 50 at the Peter Bent Brigham Hospital), all of whom were on Enovid 5.0 mg. or 2.5 mg. Enovid E, for a 15 month period. Seventy-two women completed the study, which included four individual interviews with a psychiatrist and psychologist. The psychologist used three separate measuring techniques to test mood changes. They concluded that mood changes leading to depression could not be considered as a pharmacologic side effect of oral contraception. They did, however, point out some nonpharmacologic pathways whereby oral contraception could effect mood changes. Worry occasioned by pharmacologic side effects was such a pathway. When magical phantasies about the pill are not fulfilled was another pathway. The pill was expected to cure frigidity, which in the patients' mind was due to fear of pregnancy. After starting on the pill, fear of pregnancy was no longer the crutch on which to base frigidity. Thus the patient became depressed because she realized the fault lay in her own underlying fear of having intercourse. A deeply rooted desire for pregnancy was yet another pathway. Depression while on Enovid was ascertained psychiatrically to be due to subconscious wish for another child. Guilt in Catholic women while on the pill was also a pathway, expressing conflict between the patients' choice and encyclical pronouncement.

Bakker and Dightman⁹ followed 100 women on norethynodrel in a four year program in which a large body of information was gathered by means of questionnaires, psychologic tests and personal interviews. They categorized side effects into three types: (1) pharmacologically induced; (2) "scapegoat" side effects which are the result of increased self-observation and the need to make what is new and unfamiliar, understandable; and (3) suggestion-induced side effects, which are the result of complex expectations that the patient has acquired concerning the drug. The authors concluded that depression was not a pharmacologic side effect of norethynodrel. Occasional depressive episodes are not uncommon in young, overburdened housewives. When such episodes occur in patients on oral contraception they are blamed on the pill, which fills a scapegoat function helping the patient to increase her self-esteem by avoiding the responsibility for irritability or withdrawal symptoms. Furthermore, they point out that the depressed patients

either had suffered from similar mood swings prior to starting norethynodrel or had recently encountered important adverses which made the current depression understandable.

Now a look at the effect of oral contraception on sexual behavior. From Bakker and Dightman's study,⁹ the conclusions reached were that patients using oral contraception showed no basic change in libido, and that libido changes per se cannot be considered a pharmacologically induced effect. Frequency and enjoyment of intercourse increased as a result of the patient's complete confidence in oral contraception and the absence of complicated and messy use of mechanical devices. Both husbands and wives stated that frequency of orgasm, however, remained unchanged. Two subjects indicated diminished interest in intercourse because to them the pregnancy risk had been an integral part of the excitement of intercourse. While on the pill, they were no longer playing "reproductive roulette." Mood elevation and greater sexual enjoyment due to release from fear of pregnancy was also reported by Murawski et al.⁸

In an investigation of the relationship between psychiatric complications and oral contraception, Zell and Crisp¹⁰ studied 250 private patients on Enovid by joint gynecologic-psychiatric observations over a one to three year period. They report that patients exhibited certain fears relating to oral contraception even prior to initiating medication. The fears fell into four categories: (1) fears relating to potential harmful effects the drug might exert on their body or physical state, particularly carcinogenic or masculinizing effects; (2) fears relating to changes in sex behavior. Would they become frigid because ovulation was suppressed? Would they become sexually aggressive if they no longer were dominated by fear of pregnancy? Some patients even evidenced latent fancies of prostitution and fear of uncontrolled sexual behavior; (3) fears related to effectiveness of medication, because it was oral; (4) fears concerned with future ability to reproduce or the possible adverse effect of medication on their menopause. The authors concluded that: (a) definite improvement in sexual adjustment of most patients was associated with separation of contraception from coitus, and lack of mechanical interference; (b) there was no increase in promiscuity; (c) in some wives, when use of oral contraception was proposed by the husband, varying degrees of hostility were noted. These wives, who had been attempting to make their husbands responsible for their pregnancies and thus to deny their own responsibilities, resented the husband's suggestion as an attempt to place responsibility for the pregnancy on the wives; and (d) no increase in emotional or behavioral problems was noted.

The problems of motivation for use and continuance of oral contraception are also of great interest. Kroger¹¹ has pointed out that a couple's motivation determined the type and degree of psychophysiological side effects. An emotionally well-adjusted female is usually more responsible for fertility control and more likely to follow the regimen. For one to understand the psychodynamics for the ambivalent attitudes related to oral contraception, the following should be ascertained:

1. Is the patient a cold, selfish, demanding person, or is she a warm, giving woman?

2. What is her degree of maturity?
3. How much does her emotional past (reaction to parents, siblings, menstruation, sexual and marital relationship) influence her attitudes toward contraception?
4. What deeply repressed psychologic factors are behind her surface attitudes toward sex, pregnancy and motherhood?

Forgetting a pill occasionally occurs in at least 10 to 15% of any sample. When forgetting occurs in at least two or three or more days in each cycle, it is psychologically significant. This tendency is noted in immature females who wish to avoid responsibilities. They act out their repetition compulsion patterns by not taking their medication regularly. In general, they "castrated" their mates by their frigidity and passivity during the sex act; as a group, they lacked self-confidence and so had strong dependency needs accompanied by guilty fears over their hostility. Forgetting pills seems to "feed their neuroses," as some were undoubtedly anticipating pregnancy as an act of revenge against their husbands.

Now, what about behavioral and cultural problems? We have as yet no hard data on whether oral contraception has affected morals, promiscuity, illegitimacy, criminal abortion, family life responsibility, child neglect and child abuse, either beneficially or detrimentally. The need for research in the social sciences has been proposed as one of the major areas for investigation by the newly created Center for Population Research of the National Institute of Child Health and Human Development. Underscored for such research are changes in patterns of childbearing and the effects on fertility of family structure and patterns of sexual behavior.

Lief,¹² has indicated that most contraceptive advice does not encourage promiscuity. He urges the inclusion of sex education courses in secondary schools, college and medical schools. The AMA Committee on Human Reproduction likewise has recommended that the medical profession accept the major responsibility for matters relating to responsible parenthood and population control.

In conclusion, oral contraception will continue to be an acceptable and effective method of conception control to increasing numbers of women throughout the world. At this point in time we physicians acknowledge many gaps in our understanding of the psychologic, behavioral and cultural problems associated with this mode of contraception. Further observation and research both biologic and behavioral is urgently needed to close these gaps as rapidly as possible. But in the meantime, individualizing contraceptive services to our patients, constant awareness of possible contraindications, employment of sound medical standards of careful history taking, complete physical examination including pelvic and breast exam, cytology and other indicated laboratory profiles and finally interested and adequate follow-up at least semi-annually will bridge the gap until our knowledge is more complete.

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Part II

THE SOCIAL WORKER'S ROLE IN FAMILY PLANNING

The Social Worker's Responsibility in Family Planning

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The focus of this paper will be on the responsibility social workers have in family planning and where and how we exercise our responsibility. It seemed to me that it was much too broad a task to try to cover the national and the international fronts and talk about what our responsibility is in community organization, so I am going to concentrate on what it is that we can do as casework and group work practitioners, and primarily on the interpretation and implementation of the responsibility we have in our practice.

In 1967 the Delegate Assembly of the National Association of Social Workers adopted a resolution which included a statement about social workers' responsibility in family planning:

"Social workers should take professional responsibility to assist clients in obtaining whatever help and information they need for effective family planning. Because in their day-to-day work social workers are knowledgeable about family and community resources, they have many opportunities to help clients obtain desired services. Individual social workers also have a professional obligation to work with a variety of groups on the domestic and international fronts for the establishment of family planning programs on a level adequate to insure the availability and accessibility of family planning services to all who want them."

I see family planning as an area in which we can offer preventive services. I firmly believe that the ultimate choice is our clients' responsibility. We cannot take over and we must respect their freedom to make a choice. We do have something special to contribute which can help people make an intelligent, informed choice. This is our unique knowledge of the individual, his feelings, attitudes and how he behaves in social relationships. It is high time that more social workers used their expertise to help clients with family planning.

We can now talk much more freely about birth control than we used to. Family planning has become respectable. During the Eisenhower administration, a policy decision was made that family planning was an appropriate concern for foreign aid. The decision to give federal funds for family planning only to under-developed countries with high birth rates discriminated against our own citizens. However,

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in January 1966, the Department of Health, Education and Welfare announced that federal funds could be expended for family planning services and announced the creation of a Division of Family Planning and Population.

It took a great deal of courage for the Federal government to give a family planning program official sanction in view of the fact that they anticipated a barrage of accusations of interference with religious freedom, black genocide, class discrimination and invasion of privacy.

Prior to this time a few organizations, such as Planned Parenthood - World Population, were working almost alone toward expansion of knowledge and provision of services. Now, the Federal government has been brought into the picture. Thus Virginia Insley, Chief Medical Social Work Consultant, in the Health Division of the Children's Bureau, speaking in 1967 could say: "It is obvious that Congress wants family planning services to be developed and wants federal funds used to help with this development."¹

In 1966 the Maternity and Infant Care Projects funded by the Children's Bureau dispensed approximately \$3,000,000 for family planning services. In 1968 the amount allocated for family planning rose to \$18,000,000--\$12,000,000 for special projects, and \$6,000,000 included in Maternity and Infant Care projects funds and state maternal and child health grants. It is significant that when the expected additional funds were not appropriated, the family planning budget remained intact and Children and Youth and Crippled Children's funds were pared. In addition, the Children's Bureau has been sponsoring a series of institutes and workshops for social work practitioners and educators like this one to inform them of the new resources available and to give them an opportunity to examine methods of service delivery.

The Children's Bureau is thus emphasizing the message: family planning is respectable and here's the money with which to develop programs. It is pertinent in this regard to note Margaret J. Burnstein's findings that: "In a review of articles in social work literature from 1950 to 1965, only two on family planning or related material were found. National Association of Social Workers (NASW) Abstracts lists only thirteen articles on the subject of family planning out of some two thousand classified from 1965 to 1967."²

My own career in social work illustrates the changes which have occurred. My first job in the 1940's was with a family agency. When clients brought up questions about family planning, my practical response was limited to a referral to a family planning clinic. I was well prepared by my training to discuss the nuances of personality adjustment and all aspects of marital relationships, and I knew that differences between husband and wife about money and child rearing were as important causes of difficulty as sex, but I had no preparation for helping clients come to a decision about what they wanted to do to avoid unwanted pregnancy.

As I recall, the rationalization for omitting specific curriculum content related to family planning was that if a student learned how to help clients tackle their problems in a generic way, they would

apply the problem solving method appropriately to specific problems. That meant in practice that I didn't have to worry about details like a woman's total ignorance of the subject of conception control.

When I moved to a job in a psychiatric clinic in the late 1940's, the same principles applied. Our concern was with the patients' feelings about themselves and their relationships with others. The concrete considerations of choice of contraceptive method for appropriateness and reliability were left to the family planning clinic or to the private physician to whom patients were referred. The staff, social workers, psychiatrists and psychologists spent a good deal of time talking with patients about their sexual fears and frustrations and very little time on family planning.

If, we reasoned, we helped the patient make a healthier adjustment, he would automatically make sound decisions about contraception.

I can remember working for a long time with the wife of a schizophrenic patient whose salary was the major source of support for the family. Although we talked about many of her fears and anxieties, somehow the subject of birth control never came up. I didn't introduce it and she never asked. And yet we both knew that an unplanned pregnancy could be a crushing blow for the whole family.

In the middle 1950's I was exposed to another facet of the problem when I began to work with the mentally retarded. There was an obvious need to insure mentally retarded girls and women against the consequences of their intellectual deficit, lack of judgment, and need to be loved. The recommended method was continence. In Pennsylvania, where I work, there was for many years an institution specifically organized to house "feeble minded women of childbearing age." Even where it is not spelled out so clearly, the reason for institutionalizing so many mentally retarded young adults is to segregate them from society and prevent sexual intercourse which might result in unplanned, socially unwanted pregnancies. When institutionalization is being considered for mentally retarded boys and young men, the accepted euphemism is that they are "acting out."

Later, in the same agency, I carried administrative responsibility for children in foster placement. Although the problem of illegitimate pregnancy among the adolescent girls in our care was a troubling one, it was rare indeed for a social worker to talk in any detail with the girls and their foster parents about contraception. Recognition of sexual activity was more open, but the fear of appearing to encourage promiscuous behavior was a deterrent to carrying this recognition further by actually helping a girl, if she were going to continue to have sexual intercourse, to prevent an unwanted pregnancy. I am sure that some social workers did help. My point is that the official agency policy acted as a barrier to such services to clients.

In 1965 I went to work in a maternity program in the Public Health Department. At last we operated on a fairly enlightened policy. Family planning was freely discussed, and clients were encouraged to bring out their questions and problems. This service, however, was limited to maternity patients until last year when the first family planning clinics were opened to offer services to all women regardless of their maternal status.

I think my experience is representative of our profession's history during the time I have been working. We have moved from completely ignoring family planning as a legitimate subject for social worker-client discussion to an awareness that if introduced by the patient, it was a problem to be dealt with on to a permissive attitude about a worker introducing it, to mandating the worker to deal with family planning in specific situations.

This is a long journey. But I'm not sure we have come far enough in our education and attitudes. Even today the tendency is to think narrowly of social work responsibility for family planning as belonging only to social workers who work in the obstetric service of a hospital, in birth control clinics and in public health services. This is probably because traditionally family planning has not been considered an appropriate topic for discussion in other fields of service. Yet when one stops to think, there is hardly a branch of social work in which family planning could not affect the situation. Family service, psychiatric clinics and hospitals, child placement, delinquency programs, mental retardation services, pediatric clinics--it is difficult to think of a field of social service in which family planning should not be an integral part of a total plan.

As family planning has become more respectable, the push has been to have public welfare workers include family planning in their services to clients, chiefly to women receiving Aid to Families with Dependent Children (AFDC) grants. This is a complete reversal of the former policy of public welfare programs which said to social workers: "Thou shalt not discuss family planning with clients." It asks that they do a complete turnabout from the former complete avoidance of the topic to making it now a central concern in interviews. It asks a lot of older workers who have been conditioned to one set of expectations and it asks a lot of new young workers.

I am completely in favor of women who receive public assistance having access to contraceptive information and service. However, I believe that the public welfare social workers, the majority of whom have only a Bachelor's degree, need inservice training to help them discuss these questions more skillfully with clients. And I think it is a mistake, and one which makes social work vulnerable to the accusation that we are playing discriminatory games against poor people and against black people, to think that only public welfare is where the action is.

The charge of black genocide has frequently been leveled against family planning programs, which seem to some groups to be directed primarily at limiting the number of children born to poor, black, urban residents. I am not prepared to deny that some program planners do see this as a basic aim of family planning. However, I feel strongly that women at all social levels and in all geographic areas should have the right of free choice, the ultimate freedom to control their own fertility. I think that most black women would agree with me. I have never heard the argument of black genocide advanced by a woman. It seems to be exclusively a masculine fear.

In 1964, Philadelphia's worst black ghetto in North Philadelphia was devastated by one of the first long hot summer riots. Block after

block of stores and professional offices were damaged and looted. In the central two block area there was only one untouched house. That belonged to a white physician who had a reputation for providing contraceptive service, including illegal abortion. I will leave it to you to decide whether that was an accident or whether it was protection.

In Pittsburgh last year a fight began when the Planned Parenthood Center asked for Office of Economic Opportunity (OEO) funding for a Family Planning Clinic in the Homewood-Brushton community, a black residential area. The citizens' advisory committee was urged by some members (including representatives of a black militant group) to reject the funding request. The patients organized to defend the clinic and picketed the board meetings to demonstrate their concern for saving the Family Planning Clinic.

It seems basic to assume that people of all social classes and all economic levels can use some help in making decisions about family planning and relating the need for decision making about it to the problem which they are bringing to a social agency or a health service. I grant that women of middle class background tend to be exposed to more education about family planning than poor women. I am surely not assuming that every woman regardless of social class who wants family planning service is going to need a social worker's help, but let's not make the equally faulty assumption that all middle class women do and all lower social class women don't have sufficient information on which to make a sound decision.

There are some basic differences between women who come to a private physician for family planning and women who come to a hospital clinic. A woman who goes to a doctor as a private patient knows that she is paying for her treatment. She is likely to feel independent and act as if payment for service gives her the right to ask questions of a doctor who is giving her professional care. The woman who comes to a hospital Family Planning Clinic is there because she can't afford private care. She knows (and very often is made to feel by hospital personnel) that she is getting something for nothing, or paying less than the full price. Even with Medicaid, out-patient fees are well below the hospital's average unit cost for an out-patient visit. In this context, how free can a woman feel to raise questions or to ask for special consideration?

To take this a step further, let us suppose a woman is a prenatal clinic patient. According to a study by Planned Parenthood-World Population, forty per cent of the medically indigent female population of childbearing age are in the unmarried group or not living with their husbands.³ If our patient is illegitimately pregnant, how free does she feel to initiate a request for contraceptive service? This is equal to asking a middle class doctor, nurse and social worker to condone her past immoral behavior and future sexual pleasures. There are many constraints upon her freedom of choice. Therefore, as the professionals who claim knowledge and understanding of her attitudes and feelings, it is our responsibility to initiate discussion to let her know that we have a concern for her health and her needs and that she has as much right as her richer sister to choose an alternative to abstinence as a method of family planning.

In my experience most of us practicing social work in the field of family planning have been female. William Montgomery, speaking on *The Black Community and Family Planning*, in 1968, said that he had discovered he was one of four or five black male social workers active in the field in the United States.⁴

When men have been recruited, they have been assigned to work specifically with males, to organize all male advisory committees, to work with the boy friends of adolescent girls and with the husbands of married women. I believe, of course, that family planning services must be given to the family. By that I mean that we must include the man in the planning. My definition of "the man" is he with whom the woman has a continuing relationship, whether he is her legal husband, the man she is living with or her boy friend. We must take into account his questions, preferences, prejudices and concerns, because he will exert a strong influence over a woman's continuing use of the method she chooses.

With all our appropriate concern for making sure that services are family centered, the unalterable fact is that we are offering women an opportunity to take control of their own fertility by providing methods of contraception for which they are responsible. Although family planning clinics offer instruction in the rhythm method and counselling regarding vasectomy, these choices are made by a small minority compared to the number of women using the pill, an intra-uterine device, or a diaphragm.

Therefore, in the recognition of the practical reality that it is a woman who must choose and reaffirm her choice of a contraceptive method, social work practice must be directed to helping women make an informed and emotionally reliable choice.

In our society a man will rarely be willing to discuss the subject of family planning with a woman social worker. He is much more likely to discuss it with a doctor (masculine by preference) or with a male social worker; though a woman doctor has a scientific aura which helps make her more acceptable than a woman social worker.

An interesting footnote is the policy adopted by a foundation-supported family planning program which uses neighborhood women who ring doorbells to spread knowledge of its storefront locations. These women are trained to initiate discussion and respond to the questions of a woman who answers the door. However, if a man answers they are instructed to give him the information sheet and leave promptly. It's like that old saying: If a man answers, hang up.

They do invite men to participate in group discussion because they have learned that men are more willing to participate when they have group support. These are generally led by one of the social workers.

When a social worker talks about birth control with a woman, she assumes that her client is engaging in heterosexual relationships. It is difficult to discuss ways and means of avoiding an unwanted pregnancy without some reference to the activity which may result in a pregnancy. Obviously, one cannot separate the two.

What attitude shall a social worker take in talking with a fifteen year old girl who has just delivered her first illegitimate baby? How shall she respond to a Puerto Rican woman who says she will sneak the pill because her husband would object to any method of birth control? What shall she reply to the mother of an eighteen year old girl who says her daughter won't need any contraceptive service because she is "a good girl" and after the second illegitimate pregnancy has learned her lesson?

Any response she makes is conditioned by her attitudes about sex. If she has evolved for herself a mature approach to her own sexuality, if she is comfortable with her own sexual nature, she can be accepting and helpful to her clients. If, however, she still has her own problems to work out, she may be embarrassed by the subject; she may be moralistic and judgmental; and she may take refuge behind generalities, quick referrals or the rationalization that sexual discussion is an invasion of privacy.

I truly don't think it matters whether a social worker is married or unmarried, young or old, or what her personal sexual experiences may be. The important thing for her client is that the social worker accepts the fact that sexual pleasure is a natural part of life's experience.

In my practice I have found that women will respond with relief to the message that they can talk freely to the social worker. It is our responsibility to free ourselves to convey this message. We can achieve this by including more content relating to sex and family planning in professional education, by setting up training sessions in agencies, by a fundamental openness and most importantly, by a willingness to examine our own attitudes and feelings about ourselves. Attitudes can shift significantly in response to training and practice.

Family planning services are most effective when they are offered as part of a whole range of services and not separated out as a single entity. Family planning services should be made available and accessible to more people, but the separate fragmented service, I think, will not succeed.

The decision to control and limit one's reproduction implies future oriented planning and a belief in the hopeful nature of that future. A woman who lives in poverty, who has a poor self-image, no hope for the future and little faith that she can exercise choice, may see no point to family planning. It may be, too, as many researchers have pointed out, that the one source of happiness for her and the one area in which she feels she can perform well is in giving birth to a baby and caring for an infant. Such a woman sees family planning in negative rather than positive terms. For this woman, family planning services are effective only when they are linked to the full range of economic, educational and medical services which she and her family need. A depressed patient, for example, is not free to exercise choice about conception control, which is vital to her, without the psychiatric care to improve her emotional state. Without these links the family planning gains will be short-lived.

In programs for school age girls, family planning has traditionally been limited to girls who have delivered at least one baby. The knowledge that they have already had sexual experience, provides protection from any charge of fostering promiscuity. For this age group more than any other, the basic reason for engaging in heterosexual activity and becoming vulnerable to an accidental pregnancy is the wish, the need to be loved. It is rare to find girls who are having sexual intercourse simply because they enjoy it. They want to please their boy friends or they are afraid they will lose them if they don't agree. I emphasize this point because I don't think we need worry about fostering promiscuity if we direct our services to helping adolescent girls recognize and deal with their fundamental problem of wanting to be loved as a person.

To offer a method of contraception to school age girls without insuring the comprehensive services the girls need--educationally, medically, socially--is self-defeating. What happens to a girl who is helped in her first pregnancy to get adequate medical care and to keep up with her school work if, after the baby is born, there is no one who can care for the infant so that she can go back to school?

In 1967, the Philadelphia Board of Education and the Department of Public Health where I was working, collaborated to organize the first classes for pregnant school age girls in Philadelphia. Previously girls had to drop out of school and couldn't come back until their babies were three months old. Many did not return and were considered "poorly motivated." At the end of the first school year, I got an unsolicited letter from each of the classes. I'd like to quote them because they say so clearly what these "unmotivated" girls see as their goals and their needs.

Dear Mrs. Mednick:

We think it was a good idea to set up this program for pregnant girls. We feel it would have been very difficult for us to continue our education. If not for this program, we would have lost a whole year from our schooling. This can cause a lot of students to drop out of school. We need our education to get a good job to support our children. A good education would lead to better understanding with our children, and help us to become a better mother.

We are concerned about next year when we go back to school. What will happen to the baby? It is very hard to get someone to take care of the baby when our mothers are working and the babies are very young. We would like to make a suggestion about a nursery being set up for the girls who are going back to school. It would be nice to have the nurseries set up near the schools, so it would be easier to pick them up coming to and from school.

Attention given this matter will be greatly appreciated.

Sincerely yours,

Dear Mrs. Mednick:

We are glad that we had the opportunity to continue our schooling this year, otherwise we would have lost this year in high school. The teachers took an interest in us and made us feel that they really cared. We learned a lot from the extra program such as doctors, nurses, etc. We think there should be more programs like this. Some of us will go back to school, others need help to be able to continue.

We need places for school and working mothers to leave their children. We would like more part-time jobs and more programs which will pay while training. We hope that you can help us with this problem.

Thank you for what you have done.

Sincerely yours,

The letters call attention to a serious gap in services. Nowhere in the United States is there adequate low cost day care for infants and toddlers under three. If our hypothetical girl is forced to stay at home with her baby, what motivation does she have to continue with the contraceptive method she has chosen? Don't we have a responsibility to see that day care services are available so that she can continue her education?

Studies have shown that if a teenage girl who has had an illegitimate baby does not have a repeat pregnancy within eighteen months, it is likely that she will not have more than one.⁵ If she does have another illegitimate baby, the pattern has been established and she will probably continue to produce illegitimate children.

I'd like to go back to my beginning point that these services are usually limited to the girl who has already had one illegitimate baby. It seems to me that social workers in school settings and family service agencies have a responsibility to help school age girls make intelligent decisions about their sexual conduct before they have undergone a pregnancy for which they are ill-prepared biologically, psychologically or economically because they are simply too young. It would be enormously helpful, naturally, if all the courses in sex education given to school children were truly courses in sex education and not courses in hygiene given by the gym teachers. Such a program is outlined in a guide recently published by the School Health Association delineating a whole program of sex education that starts with the kindergarten and goes all the way through high school.⁶

I think it is important for young people to learn about the emotional components of sexuality as well as to study diagrams of the reproductive equipment of men and women and how they work. If we expect young people to delay sexual experimentation and gratification, we should give them a rational explanation for our recommendations. I believe that it is preferable for immature teenage girls not to have sexual intercourse, but if they are going to, then I think it is preferable that they have access to contraceptive services to prevent pregnancy.

I have used illustrations from social work with low income families, psychiatric patients and adolescent girls to underline my position that we must deliver family planning service as part of a comprehensive system of social and economic services. We have a responsibility to offer continuity of social services as well as the social utilities, to use Alfred Kahn's concept,⁷ so that our help will be truly comprehensive and not fragmented and self-defeating.

Let me give you some illustrations of what I mean by "fragmentation of service." Mrs. B., a pregnant patient in a hospital pre-natal clinic, discussed her concern about not having any more children. After a considerable amount of discussion she decided with her doctor that she would have an IUD inserted. The doctor told her to come to the family planning clinic the first time she menstruated after she had her baby. The social worker saw her in the hospital during her postpartum stay, and said, "If you run into any problem get in touch with me." I am sure she said it routinely, because she felt that this patient was quite firm in her decision and clear about what she had to do. Two months later she heard from her puzzled patient. The problem was that the family planning clinic met only on Wednesday mornings and the patient had begun to menstruate on Thursday. The social worker and Mrs. B. figured out that it would be five months before her menstrual cycle coincided with clinic hours. Mrs. B. asked, "What do I do in the meanwhile? Stop living?"

My second illustration has a happier outcome, which was made possible by the coordination of a welfare agency, a child placement agency and a hospital.

Miss J. is a hunchbacked, ugly, little mentally-retarded woman with an I.Q. in the upper fifties. She had joined the Father Divine Church and had given herself beauty by adopting the name of Rose of Sharon. She had been lovingly sheltered until her mother died, when Miss J. was thirty-two, leaving Rose of Sharon completely defenseless and alone. It didn't take long before she came to the attention of the public child care agency because she gave birth to an illegitimate baby. That baby was mentally retarded, as were her next two babies. Previously society would have said, "Put her away," and that would have been the end of society's worries and Rose of Sharon's freedom, but since some progress had been made, the social worker decided to offer Rose of Sharon the opportunity to assess her choices and probable outcome. It wasn't easy because the client had first to convince herself that she really couldn't take care of another baby as well as herself. When she did agree, she surprised the social worker by requesting a tubal ligation. Naturally, this raised a whole set of legal problems: Was she, as a mentally retarded woman, competent to consent to surgery? Would the hospital agree to perform the operation? She was; and they did. But not without some cliff-hanging suspense. Today Rose of Sharon is functioning independently. And if men do take advantage of her financially and sexually, I think she prefers this alternative to being locked up in an "institution for feeble-minded women of childbearing age."

Social workers in medical settings have some of the greatest opportunities to help insure realistic provision of family planning

services because of their proximity to the delivery of the service. One basic function is to act as patient advocate. As long as patients are anxious about medical care, are unsure about their rights and are ambivalent about making decisions, as long as doctors are in a hurry and hospitals and doctors are concerned about procedures, reputations, legal restrictions and research requirements, someone in a medical setting will have to take the time to find out what the problem is and help the patient and the doctor get together.

The patient who has pressing social problems, such as an eviction notice or financial difficulties, is not going to utilize medical care properly until she gets some help with her troubles. She certainly can't organize herself to come to a clinic on a regular basis and decide which method of contraception she prefers if she is worried about getting her children fed.

A second responsibility of a social worker is to be an interpreter between patient and doctor. I know that this is not at present a popular role in medical social work, but I don't think that physicians have yet evolved their practice so that we can give it up. It may be that Title 19 will eventually achieve this change. As patients learn that their doctors are being well paid for their care, they may become more aggressive in asking for service. But some doctors, especially young residents who staff clinics, are still managing to prevent many of their female patients from asking questions. So I think that day is still some time in the future.

Social workers are the professionals in a medical setting to whom patients will turn for such help. It is not my contention that social workers are the only ones who can perform the functions of advisers and interpreters. Individuals with less education can certainly be trained to be helpful in these areas and free the social workers for other duties. But social work in medical settings cannot give up this essential function until someone else picks it up.

Another aspect of the interpreter's job that a social worker in any agency can do is to help the client bring out all of her fears and questions about the use of various contraceptive methods: Will I be able to get pregnant when I want to if I use an IUD? Will the pill give me cancer? Does it change my nature? What will the IUD do to my husband? I hear the pill makes you sick or get fat or bleed all the time. Whether they speak up or not, most patients have these questions or variations on the theme, and unless they can bring them out and get them answered, they are going to discontinue using the contraceptive method chosen and turn up later with an unplanned pregnancy.

In addition to helping clients verbalize their unspoken fears, social workers should learn how to answer these questions and when to refer a client back to her doctor. It is important in this area to remember a fundamental principle of social work: Don't accept the verbalized, simplistic reason the client gives first as the true answer to the problem.

Let me give a case illustration. A young, black mother of four children, pregnant again, told a social worker in an obstetrical

clinic that she couldn't accept birth control because it was against her husband's fundamentalist religious principles. It could have ended there with the social worker's acceptance of the fact that she couldn't challenge religious convictions. However, the social worker responded to the woman's unhappiness about her unplanned pregnancy. Further questioning elicited information about an apparently stable, happy family. Her husband had a steady job, he loved his children and provided well financially for the family. However--and this is a big however--there was a problem because her fear of getting pregnant made her reject his sexual advances frequently and this was the cause of much argument and tension. As she considered what possibilities there were for solving this problem, it gradually became clear to the social worker that the client had a reason why each proposed solution wouldn't work. When the social worker challenged her on this, the core problem was finally revealed. She bitterly resented her husband's sexual attitude: "He just comes at me when he wants to. He doesn't respect me as a person, but that's no reason to leave him. He's a good husband and a good father, so I'm stuck. And here I am, pregnant again." There it was. Her best defense was to say, "No. I'm afraid I'll get pregnant." To give her only a contraceptive method would remove her defense and solve nothing. By sticking to her job as a helping person, the social worker was able to peel away the cover story and get to the recognition of the real problem. Had the wife told her husband how she felt? No. They never talked about things like that. With backing from the social worker, the wife finally got up her courage and talked with her husband about her reaction to his attitudes. To her surprise, he listened and took her seriously. He refused to talk to the social worker, but he did take time off from work, came to the clinic and talked with the doctor. This was only the beginning, of course, but it was the beginning of the solution to a serious problem.

To sum up, social workers today have an opportunity to expand the utilization of family planning by their clients. With full acknowledgement that the basic responsibility for the decision to accept contraceptive service remains with the client, social workers have an enormous potential to help in this field. They can prepare themselves emotionally. They can educate themselves in the specifics of family planning. They can try to avoid stereotyped responses. They can include family planning content in their practice, wherever it is located. If we do our job in emphasizing the "social" in social work, we will fulfill our responsibility in family planning.

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Denver Family Health Services in Family Planning

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I shall discuss family planning, not as an isolated program, but as one part of total health services provided to individuals and families. I will first discuss our agency structure, then our patient population, our philosophy of family planning counseling, and some case examples.

Social workers in the Denver Department of Health and Hospitals may be assigned to a variety of services--Mental Health Team, a clinic within Denver General Hospital, Health Center or Health Station. We attempt to focus on the entire situation involving a family rather than a single aspect. Because all the social workers attached to Health and Hospitals are members of one department, all social workers are expected to be aware of the implications of family planning as it relates to family life.

The Denver Department of Health and Hospitals includes Denver General Hospital (the city-county public hospital) and the Neighborhood Health Program (the decentralized clinical facilities). The Mental Health program is also decentralized, with teams located in target areas of the city. The Denver Department of Health and Hospitals is providing prenatal, delivery, postnatal and family planning services through several decentralized facilities. These locations include Denver General Hospital, which is the hospital where all the deliveries take place as well as the facility having over one-half the out-patient prenatal and postnatal visits, two Neighborhood Health Centers which are large out-patient operations, and six Health Stations which are small neighborhood walk-in clinics. All decentralized clinics offer adult, pediatric, maternity and family planning services. These services are supported financially by city-county tax funds, grants from the Children's Bureau, Office of Economic Opportunity, and the U.S. Public Health Service.

The population in Denver is composed primarily of three ethnic groups. The largest group is the Anglos. Spanish-Americans comprise the second largest segment of patients, many of whom come from families who have lived in Colorado or New Mexico for several generations. We also have some Mexican families who have stayed in the country either legally or illegally. Our third group is the Negroes. In Denver they are in a better position to find employment than the Spanish-Americans. They also are better organized as far as their own groups are concerned and are not as limited in making use of some of the services available to them.

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Our patient population varies from one section of the city to another according to the ethnic backgrounds of the residents of a particular area. Therefore, some clinics are predominantly Spanish-American, others predominantly Negro, and in one or two the majority of patients is Anglo.

We have found a change in the patient population within the past year and a half in that many of the families who have been able to make use of the poverty programs have done so and, while they may not be particularly affluent, they are nevertheless beginning to be self-supporting and use services available in the community. Subjectively, it has seemed that more Anglo than Negro or Spanish-American families are seriously disorganized and that their problems are to a greater degree related to their inadequacies rather than to being poor. We also see a rather sizeable number of Anglo women who are transient, are frequently single, and are living in a tenuous relationship with a man.

Social Service has increased its activities in maternity services for the past four years. Recently the agency received a family planning grant from the Children's Bureau and it will be possible to give more intensive follow-up to selected family planning patients.

All the facilities mentioned have social workers who are either assigned to the obstetrical service or to be generalists within the clinical setting. In every location the social workers have been responsible for prenatal screening, on-going casework services for selected patients during pregnancy, follow-up while a patient is in the hospital, and, in selected situations, follow-up after delivery. Social Service also has family health counselors (indigenous neighborhood workers assigned to Social Service) who are an active part of this program. The Health Centers and Health Stations vary from having one to four family health counselors involved in maternity services. Denver General Hospital currently has one family health counselor assigned to the obstetrical service. The family health counselors receive a basic six months training program which is similar for each. This involves specific learning tasks in Denver General Hospital, at one of the Health Centers and one of the Health Stations. Following this period of time, they are assigned to the facility where it is felt they will best relate and there is need for staff.

An important aspect of in-service education is instruction in various methods of contraception, the physiological factors involved in each method, discussion of the reproductive organs and processes, and patients' reactions to the types of contraception. There are family planning specialists who instruct patients on the obstetrical ward and in the out-patient clinics. One of these family planning specialists has provided in-service training for family health counselor trainees and for professional social service staff at the hospital. Through the Visiting Nurse Service, in-service education has been given at the decentralized facilities.

In Social Service we have seen family planning counseling as an integral part of on-going family-centered health care. Here I am using the word 'health' in its broad sense--including both mental and physical health. Our experience has been that if patients are having

problems in relation to the use of family planning services which are available to them they tend to have problems in other areas of their lives. We, therefore, have not attempted to have counseling which would focus solely upon family planning services. During the period we have been actively and aggressively working on the maternity service, in almost every instance when a patient is seen prenatally, we ask if she has used any form of contraception, how she has felt about it, and what her feelings are about contraception in the future. When a patient has had serious conflicts in relation to her feeling about contraception, or obviously has been unable to make use of this available service, even though not to do so is extremely self-destructive, she and her family (when one exists) are, whenever possible, picked up for on-going casework services.

Because many of our patients have been extremely deprived, not only economically but also by their life experiences, many of the women only feel like persons when they are pregnant. They will state to us that they are happier when they are pregnant and consequently tend to make little if any use of the contraceptive help available to them. We have found they must come to see themselves differently and learn that there can be other satisfactions than those gained by pregnancy. These are very dependent women who are afraid to assume what we would normally consider adult responsibilities and to move into the community in any way in terms of involvement with other people. They may do well with their children when the latter are babies, but they are not able to make decisions as the children get older. Frequently, they are closely tied to their own families, particularly their mothers, although this relationship may be hostile, centering chiefly around the care of the children which the younger woman is producing.

Many of the men in our families are unemployed or minimally employed. They also do not see themselves as part of the neighborhood or of the community as a whole and feel extremely inadequate. Impregnating a woman is often the only way they have of proving to themselves they are men. Recommendation to and pressure upon their wives to be using some form of birth control emasculates these men and they can be very antagonistic toward any form of birth control counseling. Whenever possible we have worked with husband and wife in terms of the basic family relationship problems which may be present and have tried to move them beyond the restricted lives they lead. For the wives this may mean more involvement in the housing project, with their neighbors, or at a community center. For the men the most beneficial service is usually in helping them find some kind of steady employment.

One young woman who was followed for almost a year is a good example of an individual who is meeting her needs through repeated pregnancies. At the time Miss Tafoya was first known to Social Service she was twenty and was in the first trimester of her fourth pregnancy. She was extremely depressed, kept the shades down in her small apartment, had many fears about her delivery, was isolated, and was fearful that when the welfare worker learned of her pregnancy she would be in serious trouble. Miss Tafoya's third child was born with a congenital hip which necessitated a great deal of time and care. The two oldest children had been admitted previously to our pediatrics ward because of bruises and there was concern about Miss Tafoya's being possibly a battering mother. She was quite aware of her anger toward her children

and was guilty about this. She had a normal delivery and the baby was healthy. After delivery she brought up the subject of birth control to the social worker and said that the pills made her sick. The physician who checked her thought that her feeling of illness was functional and this was discussed with Miss Tafoya. Her reaction to this information was "I'll never remember to take the pill." At one time, she thought she should have a tubal ligation but really did not want this surgery and discussed it only very briefly. The social worker, during almost every interview with her, discussed Miss Tafoya's feelings about an additional pregnancy. Miss Tafoya finally mentioned that she was Catholic and this might have something to do with her reluctance. She, however, went on to say that "The Priest did not have to raise the children," and her Catholicism was not preventing her from use of a contraceptive. When she was confronted by the worker with the fact that perhaps she wanted to get pregnant again this was denied. The worker persisted in discussing this with her and generalized that some girls see becoming pregnant as a way of getting a man. She denied this but in the next interview agreed that she liked to be pregnant and that she hoped to find someone to care for her by getting pregnant. She then started to take the pills regularly, getting them from the Health Station near where she was living. During the three months after delivery when she was being closely followed, she became able to relate to other people and started having some contacts in the neighborhood. The social worker and Miss Tafoya discussed the latter's feelings of anger toward her children and her frustration at having such an empty life. She was able to gain some insight into her reasons for her angry feelings and then was less resentful toward the children. The Health Station served as a very important support during this time, becoming almost like a home to her. Not only did she have the social worker there but also she frequently would visit with one of the pediatric nurse specialists who was following the child with the congenital hip. Miss Tafoya eventually enrolled in Opportunity School, a vocational school for adults. Her case has been closed for several months but she recently called the social worker who had followed her and told her how well things were going saying "At last I am in the mainstream of the world."

A social worker on one of the Mental Health Teams has a group of young adults who have much confusion about their identities. He had seen these patients individually prior to forming them into a group. One of the young women was extremely dependent and was trying to solve her dependence and uncertainty about her sexuality by transient relationships. The social worker had been trying to help her face whether she actually wanted to be pregnant, what a child would mean to her, and what she could offer a child. Once she became part of the group, the group confronted her with some of the same questions. With the additional help of the social worker, she was able to decide she did not want to become pregnant, she probably would continue to have sexual relations, and she would make use of a family planning clinic.

One of the big problems of all projects dealing with any form of maternity service are the young girls in their teens who may or may not be promiscuous but who are having sexual relationships. These girls and their mothers frequently come to our clinics asking for assistance with birth control. The Colorado law is ambiguous in this respect and although legal decisions have been requested from the

Attorney General there has been no definitive decision. Therefore, the prescribing of contraceptive materials for the girls is done fairly flexibly, depending upon the philosophy of the individual physician involved.

In one Health Station a mother came to the Maternity and Infant Care Clinic for birth control pills. In the course of the social workers conversation with her, it turned out that the mother did not want the pills for herself but for her teen-age daughter who she thought was "playing around." The mother was planning to give the pills to her daughter and not tell her they were for birth control. The mother explained she could not talk with her daughter about anything personal. As a result of this interview the social worker became involved with the mother and learned she had many problems of which the daughter was only one. The social worker also talked with the daughter and learned that she was very much aware of what her mother was thinking and doing although her mother had not been able to talk with her about this. Because this particular Health Station is located in a rather isolated neighborhood where most of the people know each other it was fairly common knowledge that this girl was having sexual relationships with many boys. The mother eventually was able to talk with her daughter about the latter's taking birth control pills and brought her to the clinic for them. The mother was referred for psychiatric counseling in order to work with her deep-seated problems.

Another situation which occurs is that of the mother who comes asking for pills for a teen-age daughter who is not promiscuous. One of the social workers had been counseling a 12 year old girl when her mother came in and asked that the social worker refer the girl to a doctor so she could have pills. The girl was very angry with her mother about this because she was not having sexual relations and was furious that her mother did not talk to her directly. The social worker plans to continue seeing the girl regularly and her mother on an 'as needed' basis. This situation is an example of the message getting through to girls that their mothers believe they are promiscuous; or that their mothers are hoping they are acting out sexually, but where it has been impossible for them to talk together about each others' feelings. It then becomes the responsibility of Social Service to try helping the mother and girl understand why they are not talking with one another and help them learn to communicate.

The family health counselors have been particularly helpful in two ways. The first is close and regular follow-up with some patients who are simply not able to follow directions because they are either retarded or too personally disorganized. The second way has been in making us more aware of and sensitive to the amount of ignorance and fear which many of our patients have regarding any form of contraceptive help. The message which we have been getting recently from the indigenous workers is that religion is probably not so much of a barrier as it once was. Rather the barriers are misinformation and, occasionally, a fear on the part of a husband that if his wife used some form of contraception this would adversely affect their sexual relationship. We also have been aware of some of the concerns about genocide which are expressed by some of the younger militant Negro men.

One of the family health counselors has worked for a long period of time with a retarded young woman who is not capable of taking any medication regularly. The family health counselor visits her home weekly and checks the patient's calendar. The patient describes the pill she is taking as "aspirin" and the family health counselor has helped her take the "aspirin" regularly. There was another situation where a very disorganized woman was closely followed by the Visiting Nurse Service and came back weekly to the Health Station to receive her pills. For many of these patients, the personnel of the agency or the clinic itself becomes a spouse or parent surrogate.

In closing, I would like to stress that a decision for a particular type of counseling or support must be developed on the basis of careful diagnosis and assessment of the situation, just as the physicians work out the medical plan for contraceptive care according to the individual patient. The approach to helping this group of patients is also much more effective if it can be multidisciplinary. The help given by the other disciplines is invaluable and follow-up plans can be worked out which make use of the most appropriate personnel to work with an individual or family rather than the entire responsibility resting with a particular service or discipline.

Factors Influencing Use of Contraception at the Nanakuli and Palolo Family Planning Clinics: Their Implications for Social Work Practice

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Introduction

Since 1963 family planning services have been a part of the Maternity and Infant Care Projects authorized by the 1963 amendments to the Social Security Act. Since then about fifty-four such projects, supported by the Children's Bureau, have been established in rural and urban poverty areas throughout the nation, including our own state of Hawaii.¹ High-quality comprehensive maternity care has thus become accessible to a group of low-income mothers at high risk to whom services were never before available. The widespread acceptance of such services has affirmed that these women will use health and medical care when it is readily accessible. At the same time health professionals have expressed a growing concern that these facilities, and family planning services in particular, are not being used maximally by a certain segment of the target population, many of whom indicate that they already have more children than they want. Yet they continue to conceive even when the means to prevent conception are readily available.²

We have become aware in recent years that there are other barriers to utilization of services besides accessibility and availability of care. In this paper I will discuss some of the factors influencing contraceptive use which emerged from two studies conducted in Hawaii of the patients attending the Nanakuli and Palolo Family Planning Clinics.³ Both clinics are an integral part of the Maternity and Infant Care (MIC) projects and operate in conjunction with their maternity clinics. The Nanakuli Family Planning Clinic serves a chain of isolated rural communities located from twenty-five to forty miles from the city of Honolulu on the leeward coast of the island of Oahu. About seven miles from downtown Honolulu lies the Palolo Family Planning Clinic nestled in the midst of a concentrated urban low-income housing project. Both clinics serve deprived low-income persons in areas with higher biomedical rates than the community as a whole. The patient population in both clinics is largely Hawaiian and part-Hawaiian,⁴ the ethnic group that represents only 17 per cent of the population of the state (1960) but has a disproportionately high rate of social and health problems.

Different reasons led to the studies of the two family planning clinics. The Nanakuli Clinic was characterized by a high record of

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initial attendance. However, the staff was concerned about the large numbers of patients who discontinued. At Palolo the number who continued services was almost 100 per cent, but two-thirds of the women of child-bearing age in the housing project were not being reached. The Nanakuli Clinic was centrally located for the residents of the outlying rural communities, and transportation and baby-sitting services were provided. The Palolo Clinic was situated within walking distance of all residents of the housing project. Obviously accessibility and availability of service were not the crucial variables. Other more complex factors were operating. To what extent were psychological and socio-cultural factors interfering with the patients' use of family planning services?

The Nanakuli Study

Because of the growing concern about poor clinic attendance by patients, the Nanakuli study was undertaken during the summer of 1967. It was conducted by Chikae Nishida, supervising social worker of the MIC project. Although the percentage of patients who kept their initial appointments was high, too many subsequent appointments were missed, and the number of dropouts was large. Repeaters with unplanned pregnancies were appearing in the maternity clinic in enough numbers to lead the staff to question the effectiveness of its family planning services.

The final report on this study has not been completed, but I would like to share with you some of the preliminary findings which have particular relevance for program planning. The study group included 141 fecund women, married and unmarried, between fifteen and forty-four years of age, who had been referred to the Family Planning Clinic by the Nanakuli Maternity Clinic and whose pregnancies had terminated between January 1, 1966 and May 31, 1967. One hundred twenty-four (87.9 per cent) of the women had started to use some form of contraception. Of these, two-thirds (82) were still using contraception at the time of the study while one-third (42) had discontinued. This suggests that most of the women wanted and attempted to plan their families but many were unable to continue.

The difference in the record of continuance and discontinuance between the users of oral contraception vs. the intrauterine device (IUD) was significant. A higher proportion had started on pills compared to IUD's (54 per cent vs. 41.1 per cent. Five per cent had started on other methods.) However, those on IUD's showed a much better record of continuance (82.4 per cent) as compared with those on pills (55.3 per cent). Among the women who had stopped using contraception (42), the proportion who had discontinued was much higher among the pill users than among the IUD users (71.4 per cent vs. 21.4 per cent). Furthermore, the proportion who had used a method for seven months or longer before discontinuance was more than twice as high among the IUD users than among the pill users (55.5 per cent vs. 26.7 per cent). In other words in spite of the initial popularity of the oral contraceptives, the pill users were much more likely to stop using them sooner, thus increasing the risk of earlier pregnancy.

One-half of the women in the sample had stopped using contraception during the first three months following the first clinic contact. This would suggest that many of the women need help to handle the initial fears and discomfort of adjusting to the use of a contraceptive method, thus highlighting the importance of close follow-up during the early period of clinic contact.

Another finding of significance was that the quality of a woman's relationship with her spouse influenced her use or non-use of contraception. The patient's own evaluation of her relationship with her mate was elicited by asking an open-ended question, "how do you get along with your husband/partner?" Among the women (110) whose marriages were rated as "good" or "satisfactory," 64.5 per cent were using contraceptives compared with 44.4 per cent who were using them among those whose "marital" relationships were rated as "unsatisfactory" (18). Furthermore, the proportion of discontinuance in the "good" and "satisfactory" groups was much smaller than among those in the "unsatisfactory" group (24.4 per cent vs. 44.4 per cent). Other data in the study support the finding that a husband's negative attitudes about contraception play an important role in non-use and discontinuance of contraception.

The Palolo Study

From the Palolo study significant results emerged regarding the relationship of value orientation to contraceptive practice among a group of women residing in an urban low-income housing project. This research project was conducted by a group of eight second-year graduate students, School of Social Work, University of Hawaii.⁵ Interest in the subject had been sparked by the mounting evidence in recent family planning literature suggesting that the ability to use contraception is related to a couple's orientation to planning in general, i.e. their feelings about having control over their future and about their relationship to nature. Based on an assumption that behavior reflects values and that practice of contraception requires a particular set of values, the researchers believed that an exploration of client values would shed light upon other motivational factors influencing the use of contraception.⁶

The sample included seventy fecund married women between the ages of fifteen and forty-four years of age equally divided between users and non-users of contraception. The users were patients of the Palolo Family Planning Clinic while the non-users were selected randomly from the Palolo Housing population. The hypothesis that value differences exist between users and non-users of birth control was confirmed. The users of birth control generally tended to follow the American dominant middle-class value orientation pattern of being oriented to the future and of having a sense of control over nature.⁷ In contrast the non-users showed a preference for a past or present-time orientation and a tendency to feel subjugated by or in harmony with nature.

In analyzing the value orientations of the users and non-users particularly with respect to time orientation, we found that the study population fell into two groups, those with three or less children and those with four or more children. The majority of the group with less

than four children did not use contraceptives and were either present or past in their orientation. The users were distinct in that they were primarily oriented to the future. This may mean that the users of contraception who had less than four children were able to project into the future and to visualize the excessive personal and financial demands that would be made upon them by too many children too close together. The users with less than four children also showed a marked orientation toward mastery over nature, indicating that belief in controlling one's environment may be an important element in the ability to use family planning.

Among the group with four or more children, the majority were users of family planning. The non-users were primarily oriented to the past whereas the users were largely oriented to the present. This suggests that, faced with the reality of supporting and caring for four or more children, these women may be using contraception to meet "present" needs and are motivated to limit the number of children only after the family has reached maximum size.

Conclusions and Implications for Social Work Practice

The above findings have many implications for social workers working in the fields of family planning and maternal and child health.

1) One target group to whom family planning programs should be directed comprises non-users with less than four children who are predominantly oriented to the present or past. We can project that these non-users may seek out contraceptive help after the fourth child. Effort should be directed toward bringing about changes in their contraceptive behavior so that they will "plan" their families through spacing and limiting the number of children before the family has reached the point of being overburdened. These women find it difficult to anticipate the future. Its demands and rewards are too remote and uncertain. We must find tangible ways in which family planning can improve conditions for them or their children within the foreseeable future. To do this we must learn from the family members themselves what they want and consider important thus underscoring the basic social work principle that we should relate to the felt needs of clients. Successful family planning help to such young couples may well play a significant role in the prevention of family breakdown due to the social and economic hazards of too many children too early in a marriage.

2) Any successful family planning program must be geared to the individualized needs of the client groups within the context of their value system. Since values play a crucial role in influencing contraceptive practice, we should help a woman to see the rewards of contraceptive use in terms that would be meaningful to her within her own value system. In this regard, it is well for us to remind ourselves of the basic social work principles "to start where the client is and to proceed at her pace." For example, one does not talk to a client about planning for his five year old child's college education if the client's values are oriented to the present or past. The hope of providing more material things for the children they already have, or of protecting the mother's health may seem like more realistic,

attainable goals. Nor, does one suggest the use of the loop or the pill to a woman who believes that such methods would be contradicting God's will. It would be far more effective to help this patient to use the rhythm method if this is within her value system and to help her to use it consistently and regularly with a feeling of comfort.

3) To insure continued use close follow-up services which include counseling help are critical during the initial period, particularly the first three months, of a woman's adjustment to the use of a contraceptive. Even high motivation can be quickly dulled in the face of much uncertainty and discomfort, or if the basic reality needs of a family have not been met. The extent to which a person has other gratifications in life may also influence her ability to sustain the effort required in family planning. Hence we must be keenly attuned to the total needs of a woman as an individual, and provide for satisfaction of both emotional and concrete practical needs of herself and her family. This conclusion was supported by the situation at the Palolo Family Planning Clinic where the record of attendance was almost 100 per cent. Here the clinic population was small, and each patient was rewarded with the same personalized attention and close follow-up care by all members of the team which she had received during the prenatal period. In contrast, at the Nanakuli Family Planning Clinic, there was a sharp and sudden drop in the amount of personal attention and staff care after delivery. A patient's family planning efforts were not rewarded in the same way as her pregnancy had been during her visits to the maternity clinic. Due to limited staffing, only essential clinical care was provided. Social work and other supporting services were not available regularly and follow-up services were curtailed. Supportive help when a woman first starts using a contraceptive is very important; to wait until after that first missed appointment may be too late.

4) A concerted effort should be made to involve the male partner as much as possible in counseling and particularly during the early period of clinic contact. We have noted that the quality of a marital relationship and the attitude of a husband strongly influence a woman's continued use of contraception. Knowledge of a couple's needs and goals are important because a husband and wife will often have different motivations regarding conception and contraception. Each will have different significance for a husband and wife depending upon individual psychological and social needs. For example, a husband may need to continually affirm his sense of male adequacy by having more children, whereas his wife may be tired of the emotional and physical burdens of additional children. Or perhaps, it is the woman who has so little gratification out of life that she feels warm and alive only when a fetus is growing inside her, while her husband frets that they already have more children than they can afford. The level of maturity of the spouses will influence sexual satisfaction, communication, and marital happiness which in turn are closely associated with effective family planning.⁸ Doctor Lee Rainwater noted that effective contraceptive use is much more likely if it is a mutual decision reached by the couple in open communication with each other.⁹

As a result of the preliminary findings from this study, regular weekly individual and group counseling with the patients at Nanakuli was started six months ago. As the women have become more comfortable

about discussing intimate matters regarding their sexual relationships, they have taken the initiative to actively involve their husbands in family planning discussions and with good results. The social worker has found that the wives' own efforts elicited more cooperation from the husbands than her attempts to reach out directly to them.

5) In offering family planning counseling, social workers should recognize the effect of their own personal beliefs, attitudes and values on their relationships with the clients. For example, we have mentioned that the women who were using IUD's were more likely than women on pills to continue their use for a longer period of time, thus insuring a longer interval between pregnancies. In our own enthusiasm about the IUD as the more practical method for many of the clients and in our zeal to be of help, we may be tempted to impose our own value judgments on them. It has been noted that negative middle-class attitudes toward the poor, as being hopeless and apathetic, help to shape their attitudes toward themselves as being worthless.¹⁰

Social workers and other professionals also struggle with many of the same timidities and embarrassments on matters pertaining to sex and family planning as their clients, but I believe our "ethnocentrism" often precludes us from accepting these feelings. Each professional should evaluate his own attitudes toward sex, sexuality and family planning, for there can be no real involvement until each faces with honesty his own feelings. In a recent institute on family planning conducted in Honolulu, I noted that the male social workers were especially uncomfortable about participating in free and open discussion. It may be that the American male in general is ill at ease about discussion of this subject in mixed company. Thus, whenever possible male spouses should be counseled by male social workers.

Summary

In summary, the data derived from the studies at the Nanakuli and Palolo Family Planning Clinics provide certain guidelines for the operation of family planning programs for low-income groups. These data add to the mounting evidence that the target populations will use health and medical services if they are readily available and made rewarding and accessible to them by the removal of practical obstacles, such as distance, lack of information, baby-sitting, depersonalized services, etc.

However, the provision of opportunities alone is not enough to change the contraceptive behavior of a segment of the client group. The values and life styles of the groups we serve must be considered. Opportunities should be designed to relate family planning services to the individualized needs of the client and her family in concrete and tangible ways which offer realistic hope for a better life. Close follow-up services, including social work counseling, must be provided, particularly during the early period of clinic contact to sustain the client's motivation for continuing the regular and consistent use of family planning services. Involvement of the male partners may be a critical factor. Since changes in social behavior often follow changes in the social and economic structure, an effective and comprehensive family planning program should include a dual consideration of dynamic

and instrumental variables¹¹--the social, psychological, and value factors which give the motivation for family planning and the provision of readily accessible information and services which make it possible to translate motivation into action.

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When Planning Fails: Abortion Counseling in a Planned Parenthood Clinic

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Traditionally, the role of social work with respect to unwanted pregnancy has been rehabilitative in nature. Mainly, it has consisted of intervention after the fact. Much has been written in the social work literature about illegitimacy and the readjustment of the unwed mother. Most social work schools have courses which deal with the problems of illegitimacy, adoptions, and counseling girls in trouble. One general criticism of the social work profession has been its negligence in the area of preventive social services. This has been particularly true in the area of birth control. The recent focus on family planning and contraception by the social work profession represents a commendable effort to overcome this.

But what about abortion? For sometimes planning fails and sometimes it comes too late. Abortion, though not a contraceptive, is a form of birth control in the truest sense of the word. It is something which has long been neglected, not only by social workers, but by all the health professions.

In January, 1968, Planned Parenthood-Alameda County, California, began a pilot program of pregnancy testing. This program was originally intended as a case-finding mechanism to identify women in need of birth control. Hence, this service was limited to women whose suspected pregnancies were unwanted. We used a two hour urine test, plus a pelvic examination when indicated. Patients with negative tests were counselled and offered contraception. As it turned out, however, only about one-third of the patients seen had negative tests. The rest were pregnant and, of these, over 90 per cent wanted to terminate their pregnancies by abortion. And that is how our pregnancy counseling and referral service began!

Before we proceed further, let me say a word about California's abortion law. An amended law went into effect in November 1967, permitting therapeutic abortion where there is grave risk to the physical or mental health of a woman, in cases of rape or incest, or for girls under 15 years of age.

The women we have seen range in age from 13 to 49. They are single, married, separated, or divorced. They represent a range of social classes and ethnic groups. What they have in common are unwanted pregnancies. In the process of counseling these women, our social workers attempt to probe reasons for the pregnancy. Some are the result

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of method failures; more often no method was used. With today's widespread knowledge of pills and drugstore methods of birth control, the girl who has unprotected intercourse deserves some scrutiny. Our patients are not illiterates. The majority of them are bright, middle-class high school and college students who know perfectly well where babies come from.

In our experience, it is rarely true that the girl wanted to have a baby. Many of the traditional explanations for "why girls get pregnant" are based upon retrospective studies of unmarried mothers. In such studies two variables have been added: 1) the girl has had to go through with her pregnancy; and 2) in most cases, she has accepted her situation, making all the healthy rationalizations necessary for a good adjustment to a bad situation.

Counseling girls early in pregnancy, where the possibility for abortion exists, reveals some nuances. Some girls have a subconscious or semiconscious desire to become pregnant to prove their own fertility to themselves, to express love for their partner, or for a variety of other reasons. This desire may exist simultaneously with and quite separate from the fact that they have no desire to bear a child and to become a parent at the present time.

In the course of counseling, these contradictions often become clear to the woman, perhaps for the first time. Talking with a social worker may help her to acknowledge these conflicts, those different parts of herself with contradicting desires and needs. The fact of pregnancy provides a dramatic illustration of how failure to face conflicts and make conscious choices may lead to totally undesired outcomes. To explain their failure to use contraception, girls who have only recently begun having sexual intercourse frequently say they "do not want it to become a regular thing"; "it's better if it's unplanned"; "I didn't think it would happen again"; or "we had intended to stop." Many add that they didn't know where to go to obtain pills. On a hunch, I began asking the girls who used no birth control how many people other than their boy friends knew they were having intercourse. The vast majority replied, "no one." This stands in sharp contrast to the patients in our teen contraceptive clinic, most of whom learned about Planned Parenthood from close friends with whom they discussed their sexual involvement. The conflict I am alluding to is an understandable one. In a society which says sex outside of marriage is wrong, starting to have intercourse raises serious questions for most unmarried girls. The ones who have the most doubts, those who are most unwilling to accept what they are doing or to make a deliberate decision and take responsibility for it, constitute one form of high risk population.

In counseling a girl who seeks abortion, the social worker has an opportunity to help that girl recognize and come to terms with her own sexuality. The no-hassle, quickie abortion without benefit of counseling may well result in another unwanted pregnancy. Furthermore, a speedy, secretive abortion may serve to conceal what may have been a dramatic plea for help. The counseling session enables a girl to examine how the pregnancy occurred, to explore what it means to have a child and how it will affect her future. It provides a chance for the girl to articulate her aspirations, her dreams, and to consider what course of action would most likely let her realize those dreams.

Deciding what to do about a pregnancy is not a problem for most of our patients. Many girls know exactly what they want. A few wish to keep their babies with or without marriage; however, most of the girls we see want abortions. The least popular alternative seems to be adoption. There is a strong consensus among these girls that giving up their babies after nine months of pregnancy would be their very last choice.

Sometimes a client is not sure what to do. In this case part of a social worker's function is educational. He needs to help a woman understand what is involved in having an abortion by explaining the law and describing the medical procedure and its safety, as well as to help the patient understand what is involved in having a baby, especially that most inevitable of facts--that babies get a year older every year and rapidly become toddlers, school children, adolescents...

Occasionally the dilemma arises that what a girl wants and what the social worker assesses as being best for her do not coincide. For example, there is the very young, dependent girl who wants a baby to have something that is all her own. All the counselor can do is attempt to convey the realities of the alternatives; but the final choice must be the girl's, and she must realize that it is she who is choosing. The fact of making a conscious choice may in itself be the catalyst for assuming responsibility and making that choice the "right" one.

To help a client fully, the counselor must offer her complete confidentiality and the assurance of all possible help regardless of her decision. This is especially true in the case of a woman who chooses to have an illegal abortion. The woman who goes underground for help may be hesitant to discuss it afterward for fear of legal repercussions. It is important for us to assure the patient that if she obtains an illegal abortion, we still want to help and we care what happens to her. In these situations, there is an even greater need for follow-up and referrals for post-abortion examinations and contraception.

After counseling a woman who seeks a legal abortion, the social worker refers her to obstetricians and psychiatrists in the area. Planned Parenthood has compiled a sizeable list of physicians who are sympathetic to the problem and willing to accept referrals. We also make referrals to England, Japan and other countries where abortions are legal, if this is what the patient requests. We do not make referrals for illegal abortion for a number of reasons. Our objective is not only to provide women with the safe medical care to which they are entitled, but also to bring the underground above ground, in order to make the medical profession aware of the full extent of the need.

A vital part of our counseling program is systematic follow-up. If a woman decided to continue the pregnancy, did she obtain adequate pre-natal care? If she chose abortion, was she successful in getting one? Were there any medical or emotional complications? Does she need birth control now? If referrals were made for outside counseling or psychiatric help, has the patient followed through? How does she feel now about the experience and about her decision?

It has been very reassuring for us to note the general absence of guilt-feelings or other psychiatric sequelae when abortion has been the result of a well thought out decision. Many of our patients send letters or return to tell us they've had their abortion, to let us know their plans, and to share their feelings of relief and new hope.

To date, we have been successful in securing legal abortions for almost all of our patients who requested them. However, as more women become informed about the law, the liberal doctors and psychiatrists are being overwhelmed with referrals and requests for therapeutic abortions. Many of these requests come from women who qualify under the present amended law. But there are simply not enough liberal obstetricians to go around. Psychiatrists are trained to do therapy, and don't want to spend their days doing abortion consultations or their evenings composing persuasive letters to hospital committees. Finally, there aren't enough obstetrical beds in our hospitals to accommodate the women who could qualify for abortions under the law. As long as the abortion law remains in the Penal Code, retaining its rigid indications and vague definitions of those indications, hospitals will seek to avoid the stigma of being considered "abortion mills."

Bringing the underground above ground is thus serving another function: to demonstrate that the present law is failing miserably in meeting the need for which it was created. Planned Parenthood's experience in doing pregnancy testing and counseling has made overwhelmingly clear how great the need is. When we began our service in January 1968, we were seeing an average of five women a week. Now, as a result of word of mouth, a phone number in the Berkeley Barb, referrals from hospitals, welfare departments and college health services, we counsel 40 to 50 girls a week, almost all of whom live in the immediate area, and almost all of whom desire therapeutic abortions.

I doubt that there are ten times as many girls getting pregnant in the East Bay as there were last January. I am also aware that we are even now only skimming the surface, since legal abortions constitute at most four per cent of the estimated total abortions performed on California women. But let us consider the girls we are able to help. Previously these girls would have been obliged to bear an unwanted child or go underground in search of an illegal and potentially risky abortion. Enormous risks, both to physical and emotional health, have traditionally been assumed by these women because of the unwillingness of all of the helping professions to become involved.

With the present, punitive abortion laws in most states, to help a woman terminate an unwanted pregnancy has meant to incur a sizeable risk. Yet clergymen are assuming this risk. Clergy counseling services have been set up in New York, Los Angeles, San Francisco and elsewhere. Other groups of individuals have also assumed the risk, such as The Society for Humane Abortion and Abortion Counseling Service in San Diego.

What are social workers doing? In the past they have been conscientiously helping pregnant women prepare for childbirth, directing them to maternity homes and adoption agencies, or helping them

adjust to their new status as unwed mothers. This involves low risk and high satisfaction for the social worker. But it is not what most of these women want. It is not meeting the real need--a need emphatically spelled out to us by the women we have counseled.

It is my hope that as social workers become more aware of the importance of family planning to the total welfare of families and individuals, they will accept the concept of "birth control" in its broadest sense and will actively involve themselves in averting not only unwanted pregnancies but also unwanted births.

Genetic Counseling as Part of a Mental Retardation Service: Implications for Social Work Practice

SYLVIA SCHILD, D.S.W.*

Properly defined, genetic counseling is a particular branch of medical practice which "transforms medico-genetic research and theory into information and practice measures"¹ for use in the management of families concerned with or affected by genetic diseases. Obviously, social workers do not do genetic counseling per se. The role of social workers is to provide those services which assist clients with the dislocations and disturbances in psycho-social functioning which come about due to the meanings the genetic counseling has for them. In other words, social work interventions are concerned with psycho-social problems engendered by the genetic information and advice. The purposes of these interventions for the involved individual are to maximize medical treatment and social adaptation to the genetic disorder.

Though these generic roles and aims are easily seen to be inherently consistent with social work in all fields of practice, social workers have participated relatively little in specific programs of genetic counseling.² Social workers have usually had contact with genetic disorders in a tangential way within medical programs for the mentally retarded, multiply-handicapped, or patients having specific genetic diseases such as hemophilia, diabetes or cystic fibrosis.

Projection of reasons for the minimal social work participation in genetic counseling onto the medical profession affords an easy way out of self-accountability.

While some basis exists for thinking there is external resistance for using social workers more extensively in this area, important internal reasons more likely contribute to the lack of participation. Rather than to identify and make explicit those aspects of genetic counseling in which they can rightfully, professionally intervene without violating the primary medical responsibility for case management, one can speculate that social workers have tended to delegate this province in toto to physicians, just as they are inclined to do with the problems of family planning.

The purposes of this paper are two-fold: to identify some problems precipitated for families who have genetic disorders when they

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come to a mental retardation service, and to draw some implications for social work intervention and strategies needed in this problem area.

General Observations on Genetic Counseling and Its Use in a Mental Retardation Service

Wolfensberger and Kurtz, in their recent book on the management of the family of the retarded,³ point out that most of what has been written about genetic counseling is:

more pertinent to the problem of genetic risk assignment than to the handling of parental feelings. Individuals competent to give parents genetic facts are often not competent in the handling of parental dynamics, and may not be sensitive to the fears, irrationalities, etc., associated with beliefs about heredity, or to attitudes and conflicts regarding sex and reproduction. On the other hand, those trained in counseling usually lack knowledge about genetics or the techniques necessary for genetic diagnoses. As a consequence, genetic counseling has consisted mostly of recitation of genetic facts to parents and has tended to be isolated from the larger management context.

The narrow scope of the traditional mathematical probability approach is further limited in that "the use of exact risk figures in all counseling situations is not yet possible within any group of disorders."⁴ Empirical risk figures generally utilized are derived from research findings rather than from genetic theory. The empirical figures are subject to natural limitations related to the nature of multiple causality, which is characteristic in most conditions, and to the selection of the subjects on whom the findings are based.⁵ It is therefore logically apparent why genetic counseling is characteristically cautious and complicated, and why sometimes, the advice changes over time.

In the field of mental retardation, the use of genetic counseling is complicated further since the causes of mental retardation are numerous, and unfortunately to a large extent are unknown. When specific etiologies of hereditary disorders--such as Tay Sachs's disease, Phenylketonuria (PKU), Galactosemia, Hazler's Syndrome, Tuberous Sclerosis--can be established, the genetic risks of recurrence in future pregnancies are known and can provide a factual base for the genetic counseling. However, it is a sad fact that the first indication that some condition may be hereditary in origin is when it occurs in the second child.⁶ In addition to knowing the etiologic base of retardation, parents with a retarded child want to know the chances of a repetition of the anomaly in subsequent pregnancies. This interest extends also to the reproductive risks of their normal children having retarded offspring. For this reason, much of the counseling on reproductive risks in mental retardation services essentially revolves around informing parents of the normal risks of abnormalities which are present in any given pregnancy, augmented by statistical probabilities of risk derived from normative data on mental retardation. For example, based on a three per cent frequency of mental retardation in the population, the estimated risk for parents at any given pregnancy is one

per cent. The risk of a child having Down's Syndrome is higher for women over age forty than for younger mothers.⁷

Inevitably, it can be seen that family planning is a subject of vital concern for families with mentally retarded members. Impressive evidence exists showing that following the birth of a retarded child, many parents are reluctant to have more children. Indeed, family limitation often occurs.

In an extensive study of London families having retarded members, Tizard and Grad⁹ surprisingly found that only thirty-three per cent of the 211 families at risk had sought medical advice as to whether to have further children. This occurred despite documented evidence of great and widespread anxiety about further childbearing. It appeared there was reluctance on the part of the mothers to seek such advice and on the part of many doctors to initiate discussion of family planning.

Hypothetically, it would seem that where a specific genetic diagnosis is made much of the discussion content would center around the genetic risks in reproduction and parental anxieties in this regard. This does not seem to be the general situation, possibly due to the following reasons: a high priority of emphasis is placed on counselor neutrality and client self-determination once the genetic facts have been stated. At the same time, counselors tend to overlook the traumatic impact on the parents of the genetic information and as a result little attention is given to understanding the meaning to the parents of the genetic diagnosis or facts. The implicit labeling of deviancy may precipitate turmoil and trauma for the individuals involved. The expectation, perceived by parents, that they should make rational choices at a time when they are in emotional confusion, adds to the parental distress; and this serves to thwart fruitful discussion of troubling anxieties. This is especially true when some normal reticence to share intimate feelings and problems related to sexuality, marital relations and reproduction already exists.

Another reason may derive from the fact that in a mental retardation service the major focus is on the medical management of a child who is retarded. Genetic counseling, in this situation, is an adjunct service related to the establishment of a differential diagnosis and treatment plan for the child. From diagnosis onward both professionals and parents center their primary attention on the well-being of the child. Consequently parental problems precipitated by a genetic diagnosis may be overshadowed by the child-focused concerns. Hence, many parents may not view a medical service as a resource for help with their own personal concerns and they do not reveal their anxieties to the genetic counselor. Yet the side effects of genetic counseling can lead to very negative effects on the stability and integrity of parents, indeed, of the entire family. Thus it is incumbent upon social workers to be alert to the potential for development of problems by the clientele of a mental retardation service.

Some Side Effects of Genetic Counseling

In looking at the side effects of genetic counseling which present problems to parents, I shall present selected findings from my study, Parental Adaptation to Phenylketonuria.¹⁰ This disease is an inborn error of metabolism and is a recessive gene disorder associated with mental retardation. Although the study was limited to one disease, it is possible that the findings can be generalized to similar genetic disorders which are associated with mental retardation.

The study sample consisted of forty-eight families with children under care for PKU at The Child Development Clinic at Childrens Hospital of Los Angeles. A total of ninety-one parents, forty-seven mothers and forty-four fathers, were interviewed. One research area specifically explored was the nature of parental reaction to the genetic information. The importance of the genetic risk to family planning quickly became evident. Once the parents had experienced their initial reactions to the diagnosis of PKU, the conflicts created by the knowledge that it results from a genetic defect became paramount. Families were then beset by moral dilemmas. Did they have a right to produce another child who could be afflicted? Was it morally right to increase the size of the genetic pool of carriers through more childbearing? Was it ethical to risk another child needing special treatment, thereby adding to the burden of other family members? All these worries became focal if and when parents desired to have another child or if a pregnancy occurred. (Twelve mothers in the sample had pregnancies subsequent to the identification of the index case.) These concerns affected the sexual and emotional relationships of the parents. The genetic information resulted in marital strain in nearly one-half (46 per cent) of the families capable of further childbearing. These parents reported being cautious about their sexual relations; they developed strong fears of having other pregnancies. The marital strain was usually alleviated when the parents reached some kind of agreement in respect to family planning.

Where parents were still in the throes of the dilemma about having more children, the lack of solution generated serious marital tensions:

In one case, a Catholic mother was experiencing a tug-of-war between her religious convictions and a desire to restrict the size of her family. The marital couple had abstained from sexual relations while the mother struggled to resolve the conflict. The father, a Protestant, felt bound by the premarital agreement to follow his wife's religious dictates regarding family planning. Yet the diagnosis had created in him a dissatisfaction with his earlier decision and now he strongly favored having no more children. They had sought help from the clergy, to no avail. The mother's obstetrician, also Catholic, would not discuss birth control measures with her. The parents were frustrated, unhappy and upset. This was affecting their marital relationship. They admitted to feeling that their marriage was in serious jeopardy unless they could somehow find a comfortable resolution to their personal dilemma.

Nineteen families in the study (49 per cent) decided they would not risk further childbearing. This is consistent with findings reported in the literature that families with deviant children tend to restrict fertility out of fear of having another affected child, and because of parental involvement with the patient.¹¹

Various methods of birth prevention were selected by these families. Eight fathers had vasectomies, one mother was sterilized on medical recommendation, and the remainder resorted to various contraceptive methods, primarily the pill. The decision by these families to limit their size takes on added importance when noting that the size of the study families was generally small. More than half of the sample had only one or two children. Two-thirds of the children having PKU were either first or second in ordinal position in the family.

The decision for sterilization in some instances may have been rash, even unwise actions. For example:

in one family, the youthful parents had little knowledge about adequate birth control measures. The wife received little help or reassurance on family planning from her personal physician. Acting out of fear and having many unresolved negative feelings about PKU, the parents sought surgical sterilization of the father as the safest means to handle the problem. The wisdom of this drastic procedure for a father who was only twenty-one years of age may be seriously questioned, as well as the lack of adequate opportunity for this young couple to have some understanding guidance taking into account their needs and feelings.

Despite the anxieties caused by the genetic defect, the study parents revealed they were left generally to their own resources to deal with the problem. About half of the families were simply given the genetic risks without any counseling about the meaning of this information. Seven families reported they had not received that much counseling about the genetic risks. One-fourth were given direct advice about further childbearing; eight were advised to have more children; five told not to have more, apparently without relevancy to the needs and/or desires of the parents. Just four families were advised it was their personal decision to make.

The parental reactions to the advice regarding further childbearing underscored the conflictual nature of this problem for parents. One-half of the group felt troubled by, did not like, or disagreed with the advice which was given them. About one-fourth reported a lack of concern about what they were told. Six families saw the advice as being good. Despite the anxiety-provoking nature of the genetic problem, or perhaps because of their sensitive vulnerability to it, only two sets of parents sought genetic counseling from other sources.

In summary, the study revealed considerable expression by parents that the marital relationship often became vulnerable to the genetic information made explicit in the diagnosis of PKU. Normally, the threat to the marital relationship was coped with either by mutual agreement to adopt family planning on the one hand, or on the

other to have as many children as desired, knowingly accepting the genetic risks and their consequences.

The study also revealed that the self-concepts of marital partners were shaken when they learned they not only had produced deviant children but were themselves carriers of the defect. The genetic defect symbolized the presence of deviancy in themselves and evoked deep feelings of shame and stigma. Thus, one conclusion reached was that the stress of the genetic information appeared to be at the crux of the intense parental reactions which were displayed when the diagnosis was made. This is evidence that for many parents the initial reactions are extremely pervasive in their intensity and persist long after the initial diagnosis of deviancy in their child.¹²

One sees, then, that the side effects of genetic counseling can be reflected in exacerbation of problems in the following areas of individual and family life:

- 1) Family goals and aspirations, including family planning and expectations for the children.
- 2) Marital relationships, including sexual relations.
- 3) Value systems, including personal, cultural and religious beliefs guiding family life.
- 4) Individual and family functioning, including self-concepts, attitudes, feelings, and socially adaptive behaviors.

The conflicts generated by genetic information in any of these categories are stressful to the social functioning of families and their members and as such are compelling areas for social work attention and intervention.

Social Work Interventions, Strategies and Implications

The functions of social workers in mental retardation services, with but rare exception, explicitly include the responsibility to help families and relatives with their concerns about the patient and his problem. This is, of course, no less the case when the problem is a genetic one. The effectiveness in helping in this area depends, I believe, upon four basic premises guiding the social work activities and strategies of intervention.

The first assumption is that the target of service is the total family unit. The genetic factor as well as the mental retardation define the problem as a family problem. It is well accepted knowledge that the family of the retarded carries the brunt of the social stresses stemming from the retardation. Each member is significantly affected by the presence of a retarded member of the family. The way in which the family members, individually and as a unit, cope with mental retardation is as influential to their own stability and integrity as it is to the enhancement of the personality, intellectual and social development of the retardate. The same holds true for the genetic deviancy. The social problem for parents is only complicated further by a genetic

disorder, as the diagnosis is essentially a family one. In a recessive gene defect this point is easily illustrated. In identifying the patient, automatically the parents are diagnosed as being heterozygotic, or carriers of the defect. Siblings become suspect. They may be homozygotic or heterozygotic for the condition. Extended family members need to be made aware of the presence of the familial defect and their status as carriers of the defective gene should be placed under medical scrutiny. Thus the entire family may be dramatically involved at the time of diagnosis. In a dominant gene disorder, while only one parent is the carrier the reaction of the unaffected parent to the presence of deviancy within the family group, plus the risk of one out of two of a child being affected, equally dictate the need to be concerned with the total family unit. However, a variety of strategies can be used: Casework with individual members, a family treatment group approach, joint interviewing with parents, or any mix of modalities. The selection of modality will depend upon worker preference and expertise, client need and situation, and agency policy and practices.

The second premise relates to the fact that the genetic diagnosis is made in the course of establishing the etiology of lagging development or anomaly in the patient. The diagnosis may be viewed as precipitating a crisis for a family which needs constructive resolution if the family welfare and that of the affected individual is to be enhanced or safeguarded. The diagnosis, thus, can be a turning point which upsets the balance of family life and initiates a host of new problems to be resolved. Coping strategies which are applicable to the changed situation will be needed if adequate adaptation to the crisis is to be achieved. The diagnosis represents a point of no return. From this time on, the parents are confronted with a need to make decisions which must be made in the light of the genetic disorder, such as, what to do about further childbearing, what are the risks in reproduction for their normal children, should sterilization be considered, how to tell their children and others about the genetic deviancy.

If the genetic diagnosis is viewed as a crisis situation, the implication for applying crisis theory is obvious. The ready presence of both parents at the time of diagnosis provides both incentive and opportunity for crisis intervention. Understanding that normal states of equilibrium have been upset, with resulting disorganization in psychological behaviors, leads to an approach which gives priority to:

- 1) helping parents express feelings about what has happened to them
- 2) learning the new tasks, psychological and situational that need to be mastered
- 3) testing out and devising coping strategies necessary for adequate adaptations.

In this approach, the principle of client self-determination, sacrosanct to social work methodology, is always an intrinsic guideline. The expectations, however, for constructive decision-making by parents about such problems as genetic risks in reproduction should not be held until clients have had the opportunity to work through unresolved

feelings related to the crisis situation. Inevitably, it would appear there is repeated and constant reaffirmation of another valued principle of social work practice--that is, to start where the client is.

The third underlying assumption concerns the relatedness of genetic counseling to family planning. In essence, the premise is that determinations about family planning should not be made solely on the basis of genetic data which is sometimes forgotten, especially if the reproductive risk for reoccurrence of the abnormality is very high. For example, in the translocation type of Down's Syndrome, the risk in each pregnancy of having a child who is affected, either by being a carrier or having the disorder, is two out of three. Professional objectivity and a disciplined non-judgmental approach may be sorely taxed, especially when the alternative of adoption may seem more rational and desirable. The needs of many parents, however, may be such that they may be willing to take the risks involved. Interestingly, in phenylketonuria, where mental retardation is believed preventable if treatment is initiated very early in infancy, the risk loses some of its threat for parents. Baroff¹³ indicates that the focus of the professional working with families of the retarded, in addition to the estimate of statistical risks, needs to be concerned with the possible effect of a second handicapped child on the integrity of that family's organization.

The last assumption, properly placed in conclusion, goes round-circle to my opening comments. Because genetic counseling is one kind of medical practice, it is essential that a meaningful collaboration exist between physician and social worker. The implications for developing open lines of communication, respect and generous sharing of responsibilities are obvious and need not be belabored here. The implication for social workers to expand their knowledge base with concepts and pertinent information about genetics and family planning cannot be easily dismissed if the medical-social work collaboration is to be successful. It is this knowledge which can be the key help to social workers in explicitly identifying those contributions which their practice can make to enhance the functioning of affected families. It can also help to clarify the social work role in the management of genetic disorders as being needed, relevant and beneficial. Through the visible demonstration of such services, the social worker can become a valued partner in the practice of genetic counseling.

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Part III

SOCIAL WORK EDUCATION AND FAMILY PLANNING

Developing an In-Service Training Program for Social Workers on Family Planning

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The social work profession, through its national organization, the National Association of Social Workers, has voiced its concern that those families and individuals who need and want to plan their families be enabled to do so as an inherent right.¹ However, if this objective is to be realized, social workers who staff a variety of agencies, where the services provided may be only peripherally related to family planning services, will require in-service training in the family planning area in order to increase their involvement in providing family planning services.

These agencies that are peripherally related to family planning include public welfare departments, family service agencies, psychiatric services, child guidance agencies, hospital social service departments, group medical practice social service departments, and many others. Staffs in these agencies will have various levels of education, ranging from high school or less to bachelor's degrees to master's degrees in social work, and even in some instances to post-master's education. The educational level of and role expectations for these workers are two important factors in determining the content and format of a training program.

In-service training programs in family planning can take place within the agency, and can be conducted either entirely by agency training staff or by a combination of agency staff and experts brought in to present some of the more technical aspects of family planning. Also, family planning content can be provided by sending agency staff members to relevant conferences, institutes, workshops, courses and seminars, and by having them make field visits to certain resources, such as a family planning center.

I believe it is crucial that in-service training in family planning take place within the agency, and be conducted by a combination of agency staff and outside experts. With an issue such as family planning, which has only recently achieved general public acceptance, it is important that top administrators in the agency clearly stipulate the agency's policy position on family planning, thus assuring the social workers that they will be fully backed in their efforts to implement this phase of the agency program. Legislative change is not sufficient to modify the practice of social workers to include providing information, counseling about family planning services, and making referrals where these tasks had not previously been expected of them. Because of many competing responsibilities which social workers carry

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and a tradition of providing family planning services upon request only, or not at all, explicit agency encouragement through in-service training is necessary to modify practice in this area.

Every effort should be made to remove all vagueness, confusion and duplicity from written agency policy before engaging workers and supervisors in any in-service training program. In addition to making sure that agency policy in this area is clear in its direction and is supportive of the worker's efforts, a representative of top administration should spend some time, perhaps a half-hour at the beginning of the first training session, to review agency policy and purpose, verbalize administration's support of involvement in family planning, and answer questions which the staff may have.

The following experience emphasizes the importance of administrative support of in-service training in family planning. In 1968, supervisors and caseworkers in a local New Jersey welfare department were sent, two units at a time, by the department's training staff to the local Planned Parenthood Center to learn about family planning. The Director of the Center encouraged the supervisors and caseworkers to initiate discussions with recipients around family planning, where circumstances indicated the physical and emotional health of the mothers was involved. Toward the end of this training program, which consisted of a series of two-day sessions, a directive was issued by top administration in the welfare department which stated that no supervisor or caseworker was to provide any information or make any referrals to family planning centers except in cases where the client expressly asked for this service. And in certain circumstances, such as the case of an unwed minor, even when asked for information and a referral they were not to give it. I learned about this situation from a group of thirty supervisors to whom I was teaching a course on supervision through the State University's Extension Program. They asked for a discussion of this situation because they were enraged that so many people had been forced to take time out from busy schedules to acquire new knowledge which they were not permitted to use.

This vignette emphasizes another reason for conducting in-service training for family planning in the agency. This is the importance of incorporating and integrating this new knowledge into the overall program, purpose and goals of the agency which of course vary from agency to agency.

The basic purpose of all staff development is the improvement of job performance. This can be done within the agency, where the total job and the level of job performance is best known, so that any required adaptations of new knowledge to the current job can readily be made. Therefore, agency in-service training staff, already familiar with the main job to be done, should have the final responsibility for making decisions about the content, format and focus of the training, even though they may not be experts in family planning.

In-service training in family planning, as with any staff development, must take into consideration and be related to two primary factors if it is to be effective: (1) the overall goals, program and purpose of the agency (for example, many agency administrators will

not expect workers to practice in all areas of family planning; they may expect the workers to work only with those who do not want more children; they may not expect their workers to work with people who have fertility problems); (2) the performance expected of supervisors and workers and their learning needs in relation to these new expectations as agency representatives in the family planning area. The first objective should be well known to agency staff development personnel who have had prior experience in devising methods of relating and integrating any new knowledge into the on-going performance patterns of the agency. Ways of implementing the second objective can be derived from two sources. The first is written policy regarding performance expectations in providing family planning services which should be used by staff development personnel. The second source of information is the staff, that is, the supervisors and workers themselves. Their learning needs in relation to new performance expectations should be assessed before in-service training sessions are planned. This can be done by means of a simple survey. The survey should contain a brief description of the practice expected of the staff in relation to family planning, followed by a request for the information and skills they think they will need to carry out this new role. It should be made clear to them that their answers will be used by the training staff to decide on the format and content of the sessions to be held on family planning.

I am familiar with one survey of this type, although I am sure that many similar ones have been undertaken by now. The survey I refer to is the pilot survey of caseworkers in two county welfare departments which was conducted by Leah Potts in 1968.² This survey did not, however, include an assessment of the needs of supervisors which I consider essential, since line supervisors are expected to continue to provide on-the-job training in family planning through individual case conferences and unit meetings. Supervisors are key figures in implementing any new program element. Unless their training needs are taken into consideration, on-going training may be sporadic or not occur at all. The Michigan survey found that the "casework supervisor most frequently is the channel through which agency encouragement of family planning is communicated to the workers."³

This survey was conducted to assess the knowledge, attitudes and practices of caseworkers in two county welfare departments in providing family planning services to clients. The findings indicated that "84.1% of the respondents felt that in-service training sessions would be helpful. The type of information the workers wanted most related to (1) birth control methods and techniques, which was requested by 45.5% of the respondents; (2) counseling techniques and ways to discuss family planning with clients, 45.5%; (3) information regarding local family planning services, 43.2%; and (4) in Oakland County, clarification of agency policy, 20%, and 4.2% in Cook County."⁴ The training model developed in this paper is related to these four types of information which were requested by workers in this survey.

Time Required for In-Service Training in Family Planning

My own experience in conducting in-service training sessions in New Jersey for Welfare Department staff indicated that a minimum of two

days was needed to conduct in-service training in family planning. Staff development personnel may not feel that two days can be made available for this training because of the many other areas of work operation that compete for training time. On the other hand, if a shorter training period yields no results, it would be a total waste of everybody's time. For example, in the Michigan survey Miss Potts found that "knowledge and practice scores of those receiving a comprehensive two day in-service training session were higher than those without in-service training. No differences were found between those who attended a two-hour training session in Oakland County and workers with no in-service training. Thus the effect of in-service training appears to depend on the quantity and quality of training."⁵

In general, a training course in family planning, because it covers content as well as changes in social work process and functions, should not be cut to less than two full days, given either consecutively or one day a week for two weeks, or divided into four half-day sessions given on consecutive days, or one-half day a week for four weeks. After caseworkers have been back on the job for a period of two or three months, a final one-day session should be arranged to evaluate whether any practice changes have taken place and to clarify and answer questions in relation to family planning which may have arisen out of their new experiences with clients, as well as to insure that the new knowledge is being appropriately integrated into practice.

Educational Objectives

The overall purpose of a training program in family planning is to equip the caseworker with the knowledge and skill necessary to provide adequate information and counseling to all families and individuals needing them so they can make their own decisions about the number of children they should and can have, as well as about the spacing of these children--decisions which will be in the best interests of the physical and emotional health of every member of each family.

The educational objectives for workers in the training program should be clearly outlined by staff development personnel and discussed at the beginning of the sessions. The educational objectives of the family planning training sessions I have conducted were:

1. To provide a rationale for the worker's involvement in family planning counseling, including an understanding and appreciation of the importance of the caseworker's role in enhancing family life by enabling families and individuals to make use of family planning services.
2. A greater understanding of family planning as an important preventive health measure.
3. Identification and clarification of agency policy which provides the framework within which the worker will provide family planning services.
4. Knowledge and understanding of the contraceptive methods and techniques currently available and the relative effectiveness,

acceptability, advantages and disadvantages of each to enable the worker to discuss these with clients.

5. Knowledge about the total pattern of local family planning resources to enable the worker to make effective referrals and follow through on these appropriately.

6. Knowledge and understanding of clients' attitudes, needs, and values related to family planning.

7. Knowledge and understanding of methods and techniques for providing casework services in relation to family planning.

8. Information about inter-agency referral procedures, and agency recording and follow up procedures.

One Model for In-Service Training in Family Planning

If in-service training in family planning is to focus on worker performance and increasing the worker's involvement in family planning, rather than on changing basic personal attitudes of the worker, the following model could be used for in-service training in most agencies and social service departments.

The four basic components are:

1. Agency policy in relation to family planning (including the clearly communicated encouragement of family planning by top administration in the agency).
2. Agency services and the role of the social worker in relation to these services
3. Community resources for providing family planning services.
4. Contraceptive methods.

The order in which these topics are covered may be changed either by necessity--that is, the availability of outside experts--or by design, based on the interest expressed in the survey responses.

1. Agency policy in relation to family planning. Administrative direction will determine, to a large extent, the quality and quantity of services which are to be provided in the family planning area and, therefore, define role expectations for the worker. The first session should make explicit to the worker the policies, rules and procedures which agency administrative staff have developed in relation to family planning. In public welfare departments these will derive from the 1967 Amendments to Title IV of the Social Security Act, which relate to the provision of family planning services to AFDC recipients. In private and voluntary agencies the policies and procedures will derive either from the Board's directives or the chief executive's decision about the inclusion of family planning services as an integral part of agency focus, such as family counseling, medical social work, psychiatric social work or child guidance work.

. Agency services and the role of the social worker in relation to these services. Agency services and procedures in which the worker will be expected to engage should be discussed in detail. These may include all or only some of the following procedures:

(a) Counseling. If caseworkers are fully committed to the social work value of a client's right to self-determination, they will not deny any individual the freedom to make a personal choice about family planning, nor the right of access to information about the services or to the service itself should the client elect to use it.

The first discussion with a client about family planning services should be an exploratory one. The worker should ascertain whether the client is interested in obtaining services, if the client has some knowledge about family planning, and whether this information is accurate. If the client is already using a contraceptive, is it satisfactory? If the client used a contraceptive but stopped, why did she? Does the client express any resistance to continuing the discussion on religious or personal grounds? If so, these should be respected and the client should be encouraged to express these and their meaning to her.

(b) Offering information. Offering information to clients about family planning services involves making the decisions meaningful to clients by relating these services to immediate, vital life concerns on an individual basis with each client, and presenting this material in a manner which will preserve the client's dignity at all times. The caseworker must ascertain where the client is, in relation to family planning, before proceeding too far in this direction. An informational discussion about family planning does not mean telling the client that she is not to have any more children or offering an opinion on how many children the client should have. The sole purpose of giving information to the client is to provide her with an opportunity to understand the alternatives open to her so that she can make her own decision on an informed basis. The objectives of the discussion should be reinforcement of parenthood as both voluntary and responsible. The worker should discuss any medical and/or social indications for family planning which relate to the mother's immediate cause for concern.

(c) Educational activities. The worker may be expected to participate in some educational activities as an adjunct to counseling, such as providing the client with literature on family planning which has been written for the lay person. Under certain circumstances the caseworker may have to take the time to review this material with the client, depending on the client's ability to read and accurately grasp the material.

Also, the caseworker may be expected to engage in educational group meetings set up for several mothers and led by the worker, or a community service worker who has skill and experience in working with groups. There are at least two purposes for these meetings: (1) Family planning is a highly personal matter. Vague feelings, such as anxiety and fear, or misconceptions about family planning may be more easily expressed to one's peers who are in a similar life situation to one's own, than to the worker, thus providing an opportunity to help these

clients dissipate their fears and correct their misconceptions.

(2) Mothers who have already experienced an improvement in their own lives as a result of birth control can inform others of the benefits of planning one's family and encourage others to do so.

(d) Recording. Agency guidelines should be set up for recording the worker's progress in making this service available to clients. The recording should reflect the components of service which are provided for the clients.

(e) Referrals. The referral process is crucial to a client's obtaining the proper medical supervision for birth control, if she elects to do this. The degree of involvement of the worker in the referral procedure will be determined by several factors, including the sophistication of the client, the time available to the worker, the availability of community service workers to help with the referral process, the eligibility requirements of the clinics, and the collaborative efforts between agency staff and staffs of family planning resources in the community. The following guidelines for the referral process should be reviewed in the training session in the context of family planning:

(1) Make certain the client wants the referral. Is it appropriate in view of the client's age, health and social situation? If this is not ascertained accurately, the worker will be wasting her time and the client's time, as the client will not be motivated to follow through on the referral.

(2) Know the facility to which the client is being referred. What are their limitations on service, their hours, their procedures? Is there a special person whose name can be used on the referral slip, to help direct the client once she gets there? Is there a long wait before a client is seen by a doctor? Does the facility offer the client a choice of methods? What is their follow-up procedure for insuring that the client will secure adequate medical supervision?

(3) Prepare the client for the experience. Remember that fear of the unknown can be a strong deterrent. Share with the client your knowledge about the facility to which she is being referred so she will know what to expect. Perhaps knowing about the experiences of other clients at the same place can be helpful. If any forms are required from the facility, make certain the client has these and that they have been properly completed.

(4) Enable the client to act on the referral. This means ascertaining exactly what help is needed by each individual to effect the referral. Can the client go alone or will it be necessary for the worker or a community service worker to accompany her on the first visit? If the client goes alone, does she know how to get there? Does she need transportation? A babysitter? Have the necessary arrangements been made for reimbursement of the vendor when the agency is paying for the services? In the case of welfare departments, arrangements made to cover costs of services and supplies should be clarified for the client and the necessary forms should be completed by the worker.

(5) Follow-up procedures. Follow-up procedures should be set up for all referrals, both initially and later, on a continuing basis. Calls may be made on the phone to follow-up on the referral, depending on the client and the client-worker relationship. Planning one's family is a very important task. When the client has accepted responsibility for consciously planning a family she may feel a need to talk about it. She should be commended on moving to gain greater control over her own life situation. If she has been unable to act on the referral, the worker has a responsibility for learning what went wrong and to correct it, if possible. This may require collateral calls to the facility on the client's behalf.

Follow-up phone calls or visits should be made when the family planning activity of the client can be discussed, along with the other services which the client and worker may be working on. These continuing contacts provide supportive services to insure that the client obtains adequate supervision. If there are any side effects of the particular contraceptive device the client is using, do these threaten the client? Does she feel the doctor is handling these adequately? If not, a collateral call to the family planning facility may help clear this up. This kind of supportive help should be incorporated into the agency's program and structured in a way that is non-threatening to the client, so it cannot be construed as coercion or force, but is perceived as part of the total helping process in which the worker is engaged with the client. Also, through these follow-up activities, workers will become aware of gaps and overlaps in services and can bring these to the attention of administration for possible resolution. A task the worker may have to assume is that of advocate for the client, informing her of her rights and helping her to obtain the kind of family planning services she wants.

(f) Reimbursement procedures. Reimbursement procedures in public welfare departments or other agencies which assume responsibility for payment can play a significant role in involving all of the health resources--private physicians, health departments, hospitals, voluntary health agencies, anti-poverty health centers, etc.--which must participate if family planning services are to become realistically available and accessible to all persons who need and want them. When all providers of services are reimbursed fully and promptly they are more apt to cooperate in providing effective services. The entire reimbursement procedure should be explained to workers and their role in effecting full and prompt reimbursements should be made clear to them in the training sessions.

(g) Worker attitudes, beliefs and motives. Workers who are enabled to carry out the tasks related to the provision of family planning services will have an opportunity to direct their attention and efforts toward helping their clients create a bearable environment for themselves, as opposed to continuing to help their clients manage somehow to cope under the pressures of an unbearable environment. The concepts of self-determination and self-help as a means of gaining more control over their lives for clients are important steps in any rehabilitation program and they are even more important steps in such a significant area of one's life as one's family.

Since agency services cannot be discussed without some reference to the role of the worker in relation to the provision of services, this material should be covered during staff development sessions.

Implicit in the role of the caseworker is the assumption that, having accepted the job, the caseworker has accepted as part of his commitment to the agency, his clients and the profession, a concern for the welfare of the clients with whom he works. This means concern for their physical, mental and social well-being. It is a logical consequence that the worker would assume responsibility for and be given the authority to discuss family planning services when these discussions will be meaningful and helpful to clients. This should include services to minors who may be sexually active, whether or not they have been previously pregnant.

Family planning services stemming from a caseworker's concern with the client's health must be rightfully placed alongside the array of other social services which staffs of welfare departments and other agencies make available to clients around such concerns as education, housing, training and employment, all aimed at strengthening and enhancing family life. In public welfare departments, because the worker is viewed by the client as a person with authority, including the power to give or withhold financial assistance, it is crucial that the worker become aware of negative attitudes on his part which may result in the loss of objectivity in work with clients. To a lesser degree this applies to workers in other agencies as well. If the worker is to reach clients and help them use family planning services, the concept of attitude is of singular importance and should be covered in the training session.

The worker's efforts will yield negative results if he has a negative attitude, is indifferent or lacks respect and concern for his clients. The worker must fully perceive, understand and accept his role as a provider of social and educational services in the family planning area. What is more, he must adopt a positive attitude toward his role if he is to be helpful to clients. One extreme in the behavior of workers resulting from a negative attitude is a "hands off" policy even though this behavior on the part of the worker may result in the birth of unwanted children. A reason for this "hands off" attitude may be that workers feel the legitimacy of their involvement is unclear. Agency policy, procedures and training must reverse this attitude.

Social workers have tended to overemphasize unconscious sexuality to the neglect of any discussion of conscious sexuality. As a result, they may be uncomfortable about discussing sexual matters with clients. This may be reinforced by a worker's personal inhibition in the area of sex because of his own life experience. As Lydia Rapoport pointed out so succinctly in her summation of the proceedings of the Institute on Family Planning at Adelphi University in 1967, "in fact, it is most striking to a novice like myself in the family planning field who first encounters the literature and finds that virtually no attention is paid to complex areas of sexual feeling and behavior, and that conception behavior is treated as if divorced from sexuality."⁶

Some caseworkers may feel angry at a client's sexual freedom, feeling that women should be punished for their promiscuity, or men

punished for their sexuality by having to accept the consequences of their acts--unwanted children. These workers fail to consider the tragic consequences to the child and to society. Workers must be helped to see clearly that such judgmental, moralistic attitudes only serve to compound the problem and thus work against the welfare of individuals and families.

Some public assistance workers may feel that any interest on the part of a client in family planning services is ipso facto a basis for questioning the suitability of the home. So they may avoid any such discussions. Agency policy must clarify and resolve this issue.

Some workers may believe it is "not right to interfere with God's plans," which may cause them to withhold family planning information from clients. Some workers may believe that having responsibility for children may act as an incentive for moral rehabilitation by curing the sex drive, reducing sinfulness and developing maternal feelings.

Some workers may be confused or in conflict regarding interference with clients' religious beliefs due to ignorance that all religions accept family planning though some churches place restriction on birth control methods.

Negative attitudes of workers may be due to stereotypical thinking about the clients with whom they work, commonly used labels which refer to certain groups, such as "indigenous," "hard-core," "visible poor," "apathetic," "poorly motivated," "culturally deprived," which indicate that the poor are a monolithic group and as such want large families, may prevent workers from seeing each person as a unique individual. There is a need to help workers rid themselves of any pseudo-scientific notions they may have regarding the reproductive behavior of peoples of different races, ethnic groups and social classes.

Coercion is the other extreme in behavior resulting from negative attitudes of caseworkers. In public welfare departments, despite federal legislation and directives, unless state and local welfare departments develop policy and procedures to avoid coercion, there will be some workers who will act on their belief that clients who cannot support themselves, but must depend on tax moneys for financial support, should be forced to use family planning without regard for their own wishes in the matter, the choice of method, or for the many indignities or insults to which they may be subjected in obtaining these services. An attitude which may result in coercive behavior on the part of some workers is low esteem for certain racial, ethnic or cultural groups. Family planning is seen by these workers as a method of reducing the numbers of these groups. It is this attitude on the part of many people in our nation that has given rise to the accusation by blacks that family planning has been programmed as a form of black genocide.

In public welfare, a belief that clients have children to increase the grant may result in coercion.

Clients are more apt to participate in the use of information on family planning when they perceive the genuine interest, concern, and respect of their workers; when they know they have the freedom to

use or not use the information while their rights to assistance and other needed services are continued; when the worker helps them set goals that are achievable; when the clients' basic needs for food, housing, and clothing are met; and when clients have the emotional strength to involve significant people in the plan, such as father of the children, adolescents, and other relatives. For these reasons, the positive attitude of the caseworker is a crucial factor in providing family planning services.

These positive attitudes may derive from several sources:

(1) the knowledge that high fertility rates among clients has resulted primarily from the unavailability and inaccessibility of modern family planning services offered in a manner which is acceptable to the clients, which respect their privacy and dignity, and which are convenient; (2) acceptance of family planning service as part of the spectrum of services which may improve interpersonal relationships and can contribute to emotional stability; (3) understanding that there can be physiological and emotional satisfactions to pregnancy; and (4) awareness and belief that the worker's area of responsibility is the discussion of all aspects of service, and knowledge of the referral process and all available resources.

(h) The casework approach. The casework approach to be used to provide family planning services is no different than the approach used to provide services to clients in other areas of their lives. Additional knowledge, the dissipation of misinformation and appropriate referrals to adequate medical services provide the basic combination of help which most clients need and most workers can be helped to provide. It is the use of these techniques and the importance of developing clear and complete communication with clients which should be stressed. The three basic techniques generally known to caseworkers at all educational levels should be reviewed in training session in the context of family planning services. These are: (1) information giving; (2) providing support, including environmental manipulation; and (3) problem clarification. To develop workers' skills in using these techniques in relation to family planning services, some in-service training time should be devoted to role playing and script reading, followed by group discussions.

(i) Health and social indications for family planning.

Agency family planning services and the role of the worker in relation to these services cannot be discussed without reference to the families and individuals being served. Since family planning refers to those measures taken by families or single persons in order to space children or to limit family size for the purpose of maintaining the physical, psychological and social health of the family or person, on a voluntary, highly individual basis, or to increase family size through fertility studies and treatment or adoption services, social workers should become knowledgeable about medical and social indications which point to a need for family planning as a positive health measure.

Medical indications for family planning are the age of the mother, interval between births, parity, a history of premature births, infant deaths, congenital defects, abortion, obstetric complications, diabetes, cardiovascular disease, renal disease, or other medical conditions which increase the risk of pregnancy to the mother or fetus.

These indicators should be reviewed in enough detail to enable the worker to grasp their significance, since health is a rightful area of concern for the worker in any agency. This concern on the part of the worker about a mother's physical condition may enable the worker to initiate a discussion of family planning services with a client. The worker, by showing the client his concern for the client's physical condition and future health, may encourage a mother, for example, to consider preventive health measures, of which family planning is only one.

Discussions of family planning services should be initiated by a worker under the following circumstances: (1) following the birth of a child; (2) when children are born at intervals less than eighteen months apart; (3) when a mother appears physically overburdened by the care of present children because another child may be more than the mother can handle; (4) when the case history indicates persistent physical disability; (5) when a client is exposed to the risk of unwanted pregnancy, as a means of avoiding a possible abortion which the mother may resort to out of desperation.

Social indications for family planning are: (1) a mother's frustration and inability to cope with several small children, even though she is not physically depleted; (2) marital discord or conflict which is at least partially related to the inability to control fertility; (and this should be discussed with the marriage partners to bring their conflicts into the open where they have a greater chance of being resolved); (3) the presence in the home of a child or parent with an emotional problem which requires special time consuming and emotionally draining supervision by the mother; (4) the presence of out-of-wedlock children may be a social indication of a need for family planning services; (5) the occurrence of a crisis of any kind in the family, such as loss of employment by the wage earner, since a pregnancy at this time could complicate and compound the crisis situation; (6) family goals which preclude a larger family; (7) adolescent acting out sexual behavior; (8) an unwanted child who frequently becomes the abused child, which has become a grave social problem in the United States today.

One of the goals of family planning services is that every child should be a wanted child. Unwanted children, whether they are born in or out-of-wedlock, are children at risk. Except under unusual circumstances, they are socially and emotionally deprived and this deprivation may lead to acting out behavior against society. The cost both in the waste of human resources and finances to society for the upkeep of institutions and agencies which must care for these unwanted children, and the cost to the individuals involved, both parents and children, in terms of emotional and social trauma, are too horrible and too enormous for most of us to comprehend. As for the unwanted child, many psychiatrists agree that no life is more tragic or fateful in its ultimate consequences than the realization by a child that he was not wanted.

(j) Cultural aspects of family planning. Workers need to know and understand what effect their clients' cultural values, religious beliefs, fears and emotional needs may have on their clients' use of family planning. Cultural values are ideals about the way life should be lived, derived from one's life experience, woven deep into

one's personality. Since these are ingrained early in life, they may be least amenable to change, and usually only strong counter drives in the individual can effect a change in his basic cultural value system. Some of these cultural values support family planning and others may run counter to the goals of family planning, so both types of values should be known to the caseworker.

Example of cultural values which support family planning are: parents' desires that their children have a better education than they have; the value of providing a happy childhood for their offspring; the value of upward mobility in society, as represented by status or increased economic independence.

Cultural values which run counter to family planning are: The value of having a large family (fertility value) as a possible source of future security or as a manifestation of masculinity and femininity may be so ingrained in some people that even dire poverty does not provide a strong enough counter-drive to limit one's family size; the value of having male children may drive a couple to have many more children than they can comfortably nourish and support, when they have had only girls. Values opposed to family planning activities may result in "chance taking" behavior when they compete with a couple's values opposing the conception of more children.

Religious beliefs and values reinforce family planning in that "responsible parenthood" is a value stressed by all religions. Religious beliefs of some clients may involve magical or fatalistic thinking which is not necessarily related to any specific formal religious sect, or these religious beliefs may reflect the religious dicta of the church to which these clients belong. In either instance, the caseworker should take into account religious differences regarding permissible methods as well as the fact that no one should be compelled to accept birth control. Caseworkers need to be knowledgeable about the policy statements of religious groups which oppose contraception for their members.

(k) Emotional aspects of family planning. Emotional needs of clients may either support or preclude the use of family planning services and should also be understood by the caseworker who should be helped through supervisory conferences to develop sensitivity to client's emotional needs and fears in relation to family planning.

Fears and misconceptions about the procedures and consequences of family planning which may prevent clients from initiating a discussion with their caseworker may be: (1) fear that there is not help for them or that they will be refused help; (2) fear that there is something illegal about family planning or that it may be condemned as immoral by the worker or doctor. I just recently heard of a young married woman, separated from her husband, who went to a private doctor to request birth control pills and was told, "You know this won't keep you from getting venereal disease." In another instance an older woman asked for help in family planning and was told by the doctor, "You are too old to be fooling around with this stuff." I think we need to help educate doctors as well as social workers to make family planning services more effective.

3. Community resources for providing family planning services.

Communities vary greatly from having no family planning resources to having many resources under both public and private auspices. Although it is now generally recognized that family planning services should be an integral part of public and voluntary hospital services and of public health and welfare services, a wide gap still exists between expressed public policy and prevailing practice. All available resources which may be used by clients should be discussed in detail at the in-service training sessions, and visits to at least one facility should be planned if this is at all feasible.

Where inadequate resources exist, staffs in community agencies should make an effort to stimulate the development of adequate services. When social workers become involved in community planning for family planning services, they have a responsibility to see to it that these programs do not have built-in social barriers to the use of the services, such as degrading eligibility requirements, inconvenient hours and/or poor location of clinics, unacceptable attitudes of personnel operating the clinics, and that contraceptive methods offered are not limited to those which may be in direct conflict with the values and religious beliefs of those being served. Too many clinics are concentrating on the use of the pill or the IUD, and are ignoring all other contraceptive methods.

4. Contraceptive methods.

In the in-service training program, information about contraceptive methods should be presented by a physician specialist with current family planning experience. This should be supplemented by audio-visual aids, including film strips, a wall chart of the reproductive organs of the male and female, and a kit containing the various contraceptive methods. The physician should be given sufficient time to discuss the anatomy and physiology of reproduction, the process of conception, abortion, and contraceptive devices and techniques. It is important to cover all contraceptive methods.

Evaluation of the In-Service Training Program

Learning new behavior and modifying old behavior requires that the learner have an interest in the material to be learned and have an incentive to learn or change his behavior--that is, a purpose or use for the new or changed behavior. Therefore it is important to evaluate whether the content and format of the course met the needs and interests of the workers sufficiently to effect any change in their practice, i.e. their behavior toward their clients in relation to providing family planning services.

Part of the last session should be used to complete an evaluation form devised by staff development personnel to see whether or not the program has increased the worker's knowledge about family planning. A half-day session should be arranged for participants two to three months after completion of the training course to determine whether any practice changes have occurred in the family planning service area, and if so what these changes are. The entire course can be reviewed and discussed at this time.

Based on the results of the evaluation, staff training personnel should evaluate the need for further staff in-service training and set up an appropriate plan for continuing in-service training based on expressed need. Responsibility for this may best be delegated to line supervisors to be done on an individual or unit basis. If this is the plan, the department's in-service training supervisor will need to work closely with the line supervisors to ensure continued uniformity in training. Weekly supervisor-worker conferences following the training program on family planning should allow for time to discuss the worker's activities in the family planning area. This will help him organize his work more effectively and implement the goals set by the agency in relation to family planning service.

Conclusion

This model for providing on-the-job training in family planning for social workers can only serve as a general guide for developing in-service training programs. Each individual training program will need to be geared to the needs of the staff in the specific agency in which training occurs.

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Family Planning Content in the Graduate Social Work Curriculum

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It would be logical, if it were not so complicated, to establish the need for teaching family planning, roughly sketch the pertinent knowledge, value, skill base to be taught and learned, and suggest where and how learning experiences might be arranged in the curriculum. An orderly presentation presumes however, some uniformity and stability of curriculum patterns throughout schools of social work. But if anything characterizes social work education in the late 1960's, it is the theme of experimentation and innovation, diversity and flexibility. An orderly presentation also presumes that we have a stable student climate, whereas the current student climate is unlike any other in the history of social work education.

In order therefore to appreciate some of the problems in building curriculum content in family planning, some general observations about the current scene in social work education seem necessary as a backdrop. I should say at the outset, having recently completed a year in which a considerable part of my energies went into trying to find a way of working effectively with student representatives on curriculum casework committees, and at points of sharp difference, having to "negotiate" the nature of learning experiences, I was somewhat startled when I received this invitation to find that educators were still being asked what to teach. I can only speculate that there was no student representation on the planning committee.

The changes that are taking place in students responses to their educational experiences leave us less than the limited time we have always had for reflective examination of our weaknesses and complacencies, or disciplined curriculum revision. We are often under pressure to respond with immediacy to reasoned and unreasoned, but always passionate, urgencies of students. It is something of a cultural shock to find oneself in the establishment.

First, students complain about the tightly organized curriculum which allows for little freedom of choice. They remind us of the diversity of learners, and clamor for more individualized programs of study and more electives. At the recent conference in Atlanta of the Council on Social Work Education Project on Integrative Teaching and Learning, student representatives from the eight participating schools voiced, among other dissatisfactions, their objection to the fixed

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core curriculum. While some liberation from the required curriculum has unquestionable merit, the question of how to insure basic coverage and safeguard professional competence remains.

A second change appears in the shift in life style of social work students from theoretical to experiential learners. This has its aspects of irony. Social work education has spent the last two decades trying to achieve academic respectability. It has striven to help students learn to think as well as feel, and sometimes think instead of feel. It has made impressive gains in teaching theoretical conceptions and creditable progress in systematizing empirical knowledge and in substituting analytic for descriptive teaching. It has developed a degree of sophistication about learning processes and curriculum building, and enthusiastically has tried to incorporate from Jerome Bruner insights about the structure of a subject and whole-parts learning, and from Ralph Tyler the principles of integration, continuity and sequence in the organization of learning experiences. And now it almost appears as though we are being asked to lay to rest the educational theory and principles we have labored to acquire. Contemporary students have a growing skepticism about high level abstractions or conceptual matrices. They seem to have less patience with theoretical formulations which do not appear to have immediate utility. While they are, on the whole, intellectually superior to their predecessors, they are in another sense anti-intellectual. Their existential stance, their insistence on the primacy of experience, comes through in a variety of ways including the increasing demand for encounter groups, sensitivity-training, conversion of classrooms into micro-labs for any form of experience that will heighten their sense of selfhood and bring them into closer contact, communication and interaction with others, including faculty. With faculty they ask for real instead of counterfeit communication. This past semester, in my final seminar, where students select their own topics for panel presentation, one student interrupted her presentation and invited her fellow students to respond to how they were experiencing her. A gush of self-expression and verbalized self-examination followed. At another point students complained of my lack of reciprocity when I did not share my private feelings as they did theirs.

Consistent with their accent on experiential learning and irreverence for the wisdom of the past, is the students' preception of field work as the vital part of the educational program. Field work has always engaged students more than the academic classroom. Contemporary students, however, are more restive and vocal about the gap between practice and idealized conceptions of social work's roles and goals than were their predecessors. The divorce of theory from practice, formerly kept somewhat secret, is now public student knowledge.

A third shift is the changing faculty-student role relationships, labeled participatory democracy. For social work students this ranges from demands for student representation and voting rights on all committees including admissions, scholarship, field work, student progress and sequence and curriculum, to a plea for the model of the autonomous learner. Students reject what they see as a teacher-dominated curriculum. They are questioning not only the authority of role and power of faculty, but the authority of competence. They

rightfully reject any notion that they can be led by the hand through the knowledge wilderness to some illuminated clearing, but they distrust the fact that their desire for more active participation in the learning process is warmly supported by most social work faculty. As one student put it, with vehemence, "we are not end products of your educational delivery system. We have the right to participate equally in deciding what we should learn and how." Students make it clear that they did not come into graduate education to be acculturated or socialized to the profession, but to change it, and especially to change those professional values that are antithetical to an activist orientation.

The above examples give just the flavor of what we are confronting or how we are being confronted. I have put the case too strongly in some instances. We still have some students who are compliant learners, some who are primarily occupationally oriented, and the more traditional student, but I have not put the case strongly enough for the militant political activist. Very soon we need to take a hard look at the issues posed by the student movement as it relates to education for the professions. Some of the liberal and radical assumptions of the present time may threaten our traditional notions of preparation for responsible entry into the profession unless this, too, is undergoing subtle revision. This does not deny the validity of some of the student complaints, nor the potential of the student voice in raising crucial questions that push us to enlarge our views. It does suggest, however, that in our eagerness to respond to student challenge and out of fear of being labeled the oppressors or assigned to perdition, we may risk abandonment of our role as guardians of educational standards.

The major reappraisal we are undergoing in relation to profound questions about the nature of the social work profession, coupled with student turbulence are characteristic of today's academic community which must be taken into consideration if we are to avoid tunnel vision in thinking about teaching family planning. We are on the brink of significant refashioning of social work education, and what is emerging is only dimly visible. We should not be guilty of the "as if" phenomenon--as if we only need be convinced of the central importance of the family planning cause, create an incision in the current curriculum, excise some unnecessary appendage, and replace it with family planning content.

What then can we do? Well, despite the disquieting situation, there can be no professional debate about the fact that family planning is a highly relevant human right, a highly relevant social goal, and one that is highly relevant to social work's central purposes of prevention, and of the enhancement and restoration of social functioning. It should therefore be relevant for contemporary students. Winifred Bell suggests, as a way of ordering priorities, that the crucial question for professional social workers may often be what can we afford not to support rather than how many goals we can press toward simultaneously. Even putting aside for our present purpose the crisis of over-population, which many serious social thinkers consider the greatest peril facing mankind, we simply cannot afford not to support family planning. But it will not be enough to espouse the cause and marshal some supporting data. We will need to provide learning

opportunities that light up the minds and hearts of students, that link knowledge to action, and are responsive to students need for engagement. Otherwise the ideas that arouse emotion in the classroom may stale and be discarded.

My reflections will therefore be directed as much to how we might teach family planning as what to teach. As for the what, I shall take the liberty of not proceeding systematically through the curriculum sequences. For one thing, as I mentioned previously, there is less standardization in curriculum arrangements or even content emphases than heretofore, and more dramatic revisions are in store. The emerging new blends (some of which are synthetic) in methods teaching, the social problem focus for curriculum organization that some schools have adopted, the complex of field experiences and training centers beginning to replace single agency field placements, and the experimentation with the length of time for professional education are among the more familiar changing educational patterns. Secondly, I am more convinced that we know or could find out what to teach than whether at this moment in time, we have high motivation to do so. It is not that we lack commitment. Social workers are never short of commitment. Rather a complex of obstacles and deterrents appear to impede our motivation. The chaotic mass of knowledge which has accumulated, the number of special interests pleaded before the schools, and the number of simultaneous educational innovations leave us breathless and almost strangling. Add to this state of affairs the student rumblings and the problem of motivation begins to appear understandable although not defensible. I have not known a social work teacher who did not readily acknowledge that family planning is a vital concern for social work. I have known many who add guiltily that they only teach it peripherally if at all.

I believe we will make faster inroads if we recognize that considerable core content relevant to family planning already exists in curricula. Where we need to make a concerted and conscious effort is in the explication of the linkages and interrelationships between existing knowledge, value, attitude, and skill themes and family planning. In other words, we need to structure learning experiences that facilitate and maximize transfer of learning. It is only at first glance that family planning may appear as a narrow and specific case. On closer inspection, it interweaves and integrates with and is germane to the whole curriculum. One could not begin to teach family planning without the conceptual tools of primary prevention, epidemiology, population-at-risk, demography, and crisis theory. One could not teach family planning without teaching students a framework for analysis of the major social problems of poverty, race, and health and their interfaces. One could not teach family planning without helping students to critically examine social policy issues and goals. One could hardly teach family planning without teaching students to understand the complex organizational, political and economic factors that underlie current institutional barriers to effective development, organization and delivery of health and welfare services. Could family planning conceivably be taught without teaching students to understand the developmental crisis of pregnancy, including the problems of maternal and infant mortality and morbidity, and the biological insults to children of high-risk mothers? Students can only appreciate the urgency of the family planning cause, when they understand the social

and psychological basis and cost of unwanted pregnancies. They can only understand the implications of family planning for family life when they understand the psychodynamics of marital and family life, and the sociology of the family in relation to changing role relations, family size norms and aspirations, cultural value orientations, etc. Without an appreciation of the whole tangle of personal, professional and social values and beliefs that underlie all human decision making, students would be unable to understand the raging controversies that have surrounded family planning and the opposition that continues in some states, some ethnic and religious groups, and some individuals. Finally in order for students to be able to distinguish facts from assumptions or knowledge from values in family planning, or to search for new knowledge, they require a research orientation that helps them put under scrutiny both our knowledge and our problem-solving processes. All of these content themes, and more that I have not included, presently exist in social work curricula. Where we fail, however, is in helping students to grasp and use the combination of insights acquired in other contexts. The argument I have advanced, and I have for the moment excluded the methods courses and field work, does not deny that there are policy issues, issues around methods of service delivery, legal issues, value issues, and biological, psychological and sociological knowledge areas that are more specific to family planning. I am suggesting, however, that students can make the transpositions when we call attention to interconnections. When we provide opportunities which foster high recognition of interconnections, they can then transpose the relevant insights. Learning opportunities, like conception, should be planned rather than accidental.

When we turn to social work's interventive methods and its practice theory and principles (and why after all do we teach purpose, knowledge-values and sanction, if not to underpin informed practice and for competence in doing), again what is currently taught about working with all client systems and toward institutional and social policy change has direct application to social work's role in family planning. It may be true that we have not yet built up sufficient social work practice experience in family planning services, or begun to abstract knowledge from what social work experience we have, to know what modifications in methods or techniques may be required. But in any event, I would be wary of an emphasis in teaching specific techniques or programmatic discoveries that may meet with success but fall in the category of intuitive artistry or styles in strategy. For one thing we have hopefully moved away from "how to do it" methods courses. For another, although some fundamental principles will prevail, methods as well as techniques are not eternally enduring and change in response to new knowledge and social change.

But there is a level of practical and applied knowledge about birth control that poses more dilemmas for the educator. To what extent for example should the biological details about contraceptive technologies be taught? How much should students be taught about problems in usage and continuance? Is it sufficient for students to understand in general the influence of culture, religious beliefs and values on behavior, or the effect of ignorance of facts and resources on problem-solving behavior, or that motivation is affected by the apathy and resignation resulting from massive deprivation, or that human ecology is as much a determinant in behavior as internal

motivations? Should students be familiar with research efforts which attempt to get at sexual attitudes and behaviors when fear of pregnancy is no longer present? Should we impart the information that some women believe any attempt at fertility control "cuts the nature," or that some men believe it interferes with sexual pleasure or perceive female contraception as a threat to ego or masculinity? I am referring more to the kind of knowledge accumulating out of experience that is appearing with great frequency in the ladies' journals. Is there enough challenge for graduate students in information that is available for popular consumption? But then one must quickly add that it is amazing how ignorant and naive graduate students can be about the minutiae of birth control and the attitudes evoked by various contraceptive practices, and even of the sexual experience itself. I do not wish to be misunderstood. There is no question that students need a good deal of practical knowledge in order to understand clients' unspoken fears and veiled attitudes about birth control and sex. My question pertains to whether or not this belongs in graduate curricula.

This is where some confusion sets in for the educator and we see-saw back and forth trying to juxtapose our interest in theory and scientific abstraction and the liberal education component in professional education, and our concern that we not be irresponsible theorists. Can we not rely on the fact that the quest for knowledge for a professional is a life long task and that practitioners will acquire knowledge out of the day-to-day experience? Is there enough durability in this kind of information, or will some of it quickly become obsolete? A breakthrough in medical investigations for example, could radically alter the picture. John Gardner put it vividly. "The rush of change brings a kind of instant antiquity." And Whitehead put it equally graphically, "Knowledge does not keep better than fish." These questions are not easily resolved and plague educators in all of the professions. Professional education faces in two directions at once: Toward developing knowledge and theory builders, and professionals with vision, who will correct our myopia and astigmatism; and simultaneously toward developing practitioners with skill and competence in helping. Finding bridging concepts and a middle range level of teaching is, for most of us, a continuing struggle. We must constantly grapple with how to get from the client problem to theory and then from theory back to the client. To keep physicians abreast of the deluge of new research findings, IBM and other firms are developing computers to store medical information to help physicians improve diagnosis and treatment. The applications to social work are self-evident. Although much specificity must be left to daily practice on the job, and to self-generated learning rather than teaching, we traditionally rely on the use of illustrative case materials with some specifics and refinement. This arises out of the pedagogical principle that teaching theory without practice is sterile or as Whitehead put it, "Without generalization there is no reasoning. Without concreteness there is no importance." In my experience, the use of students' own practice illustrations of family planning provide lively material for reflective teaching and learning. Material is introduced where discussion has been initiated, a referral made, or counseling attempted. A host of diagnostic considerations are examined as well as the students' activities. More often students volunteer to describe case situations where the issue of family planning might have been appropriately raised, but where an interplay of personal conflict,

professional uncertainty and agency policy ambiguity operated to nullify the students' good intentions. There is high involvement in a classroom when the discussion derives directly from the students' experiences.

This past semester a student described her keen sense of frustration with a situation she was called upon to handle in a municipal general hospital. The clinic physician wished to prescribe the pill for a fifteen year-old girl who had delivered an out-of-wedlock child. He was unable to obtain her mother's consent and referred the situation to the student. The mother was a non-English speaking Puerto Rican who flatly refused. Even with the use of an interpreter and an indigenous aide, the mother simply kept repeating that the only solution for her sexually active adolescent lay in marriage.

I wish I could report that we solved the problem. We did not, and I don't need to add that the individual case is not taught, but generalizations sought. This kind of practice illustration, and this applies also to illustrations of practice with groups or in community work, leads not to pedantic instruction of dispensing teacher wisdom but to a joined process in which teacher and students give reasoned consideration to the issues involved. In the course of discussion students are sensitized to the unknowns to which scientific inquiry and empirical investigation must address itself, as well as to those knowledge areas where we are on firmer ground. While not all the knowledge required for understanding can be brought to bear on every issue explored, it can at least be identified. Among the questions and issues raised, for example, by the practice illustration were: Does giving birth control service to teenage unmarried girls sanction and encourage promiscuity? Is there a change in adolescent sexual behavior in relation to advances in contraceptive methods? Student attention is drawn to accumulating data that suggest more effective fertility control is less significant for sexual behavior than culturally patterned attitudes toward sex. What role can sex-education play in the schools, and what is social work's role? What value conflicts arise for the worker in his competing loyalties to the adolescent and her offspring and to the mother and parental rights? Is this parental neglect, or what framework helps to understand the mother's behavior? What is known about how change in cultural attitudes can be effected? Are there circumstances under which social control is a legitimate social stance for social workers? How do we balance our strong commitment to individual freedom of choice and social responsibility?

Birth control is a value laden issue in the most private and most public sense. Several writers have pointed out that little systematic attention is given to the use of values in practice. Education must take the lead in strengthening students' appreciation of moral, ethical, social and political value considerations in general and in family planning specifically. In my introduction to the Alpha volume, I tried to deal with some of the value issues and ambiguities for the social work practitioner, the agency and the profession. Returning to the student material, let us move closer to the immediate concern of the student. Is a traditional treatment focus for the girl indicated? What are the elements of psychosocial diagnosis that will guide us? Will intervention be more sociotherapeutic than psychotherapeutic, and why? Is intervention in the school system to facilitate the adolescent's return to school indicated? Is group process the appropriate

method of intervention? Since changes in state law and liberalization of policy with respect to minors now exempt a physician from liability if in his judgment there is hazard to the health of an adolescent or her future children, is intervention with the medical system indicated?

Every educator knows that the more problematic in nature situations are the more learning activity is elicited. Students weigh the alternatives, utilize knowledge learned elsewhere, and feel the problem is compelling enough to want to understand it. They cast around for hypotheses, and competing hypotheses lead students to controversy among and within themselves. The teacher's input of knowledge to sharpen insights is of no greater importance than is helping students to reason pertinently, to see their inconsistencies, and to expose where understanding of self-determination is overly facile leading to a mis-carriage of the right to freedom of choice in matters of fertility. This is experiential learning in the classroom. In addition, the use of practice material serves to heighten the intimate and reciprocal connection between class and field.

One of the disconcerting findings that a study conducted at Adelphi University School of Social Work revealed was the significant lack of knowledge of family planning resources among graduates three years after graduation. Obviously graduate schools cannot be expected to teach resources. But somewhere we all fail when practitioners do not exercise sufficient initiative to acquaint themselves with available resources. Our critics have accused us of training for incompetence or training people out of the small things an untrained worker might perform naturally. One can quote William Blake, "Who will do good, must do good in the minutest particulars," or Jules Henry, the social anthropologist, who in outrage against the GI (General Incompetence) syndrome said, "there's no such thing as minor surgery, there are just minor surgeons," but exhortation cannot pass for education.

Another finding of the Adelphi study, although small in scope and not generalizable, and surely not unique to Adelphi, will lead us to feel instruction where I believe a considerable share of responsibility for family planning teaching must lie. Most respondents reported that they recalled that family planning was discussed more in the foundation sequences than in methods courses, and more in case-work than in other methods, but practically no respondent recalled discussion or actual experience in field practice. This is hard to understand. Family planning is a personal need which cuts right across all fields of practice and calls into play the whole spectrum of social work service. Field instruction could systematically include relevant knowledge and skill content although the subject would naturally come up for more intensive consideration in family planning, pre-natal and post-partum clinics, public assistance programs and in all settings where low-income individuals and families are to be found. It is of dubious value for students to learn about liberalized national policy, or that the NASW policy statement speaks with volume in shoulds and oughts about social work's responsibility in family planning, and then have no supporting experiences in field work or little visible evidence of models for social work activity in family planning. Students can hardly be blamed for responding with impatience and disillusion with professional or societal values when our high-minded goals and

commitments lack any semblance of implementation. In the orientation of students to agency policy and function, a natural opportunity is afforded to discuss policy, non-policy or ambiguity of policy with students and to encourage questions. And they do raise unsettling ones! Students have been known to push agencies to articulate or clarify policy when an undefensive and responsive climate exists. Students can be helped not merely to agonize about gaps and lacks but to have some small practice experience with participation in community organization efforts for provision or outreach. Field instructors should not await the students' first frontal encounter with the issue, but should introduce content as part of fixed curriculum content to heighten students' awareness of at-risk client populations and of appropriate levels of intervention. Finally, agency based seminars should be led by field instructors with special experience, or conversely, campus based field seminars should be introduced. The obvious principle here is the importance of facilitating continual and reciprocal feedback between class and field.

In line with student demands for more options, the general learning style of today's students and the fact that some may want to pursue the subject in greater depth, a number of innovative variations in learning experiences suggest themselves. The use of peer learning groups has much to recommend it in maximizing independent learning. Fevered with the idea of doing their own thing and skeptical that their professors could bring any enlightenment to a course on the crisis of urban youth, students at one school arranged an elective with no teacher in charge. They became the instruments of their own learning, often advocated but usually postponed until a degree legitimates independent learning. In this instance, students defined their own learning objectives, formed sub-task groups to update bibliography, develop assignments, etc. The basic assumption, however, was that understanding of the problem and more effective problem solving strategies could not be limited to books, nor could the concern for social change remain at an ideological level. As I understand it, the students developed a series of laboratory experiences, including talking with ghetto youth, working and living with them. They returned to the classroom at predetermined intervals to share and analyze their experiences. Faculty as well as students were most enthusiastic about the results. This has implications for the active role students can take in shaping their learning experiences through either individual or group independent study in family planning.

Another learning device that holds potential for more active engagement of students and utilization of their interest in self-expression is the student sponsored workshop. A day freed from normal classes could be set aside for a workshop on family planning where students could carry the major responsibility for planning and delivery of content. A heightened desire to learn, the power of peer learning and the learnings derived from the mistakes are obvious advantages over the modes of the teacher as a transmission belt of knowledge.

At one school where students were asked to devise a game that illustrated their understanding of a social problem in its micro and macro aspects, the results were imaginative. One student designed a game which she called "knocked up" and as I remember it, it was a kind of programmed learning and behavior shaping for clients about the

hazards and obstacles to self-realization when safeguards against unwanted pregnancy are not taken.

Team teaching around aspects of family planning is a pedagogical device that, when properly used, can heighten students' engagement by exposure to diversity and healthy mutual challenge between faculty members. Because of the artificial subdivisions in knowledge and curriculum construction, fragmentation inevitably occurs. Team teaching is one device to heighten integrative learning.

Family planning is threaded with knowledge from medicine, genetics, nursing, sex-education, sociology and so on. We continue to extol the value of interdisciplinary education, but make insufficient use of it. Most schools have access to a number of disciplines that can be creatively used to help students see the subject of family planning in the whole.

There is a trend toward some degree of specialization in schools of social work either because of educational philosophy, special talent and resources, or unique local needs. It may be that schools in universities where medical schools or schools of public health exist can be expected to provide more intensive preparation in family planning to prepare a cadre of professionals as specialists for leadership roles in family planning.

In conclusion, I have chosen to range far and wide, and provide only tentative suggestions and uncertain guides. In our national enthusiasm for the cause of family planning, we are prone, especially at conferences, to exaggerate what should and could be taught. When we then fail to live up to our excessive self-expectations, our sense of frustration is exacerbated. Nor is the curriculum building achieved by platform pronouncements. It is a collective effort that every curriculum committee must do for itself. The place to start is in the clear articulation of learning objectives. What is the mix of transmission of knowledge effecting attitudinal change or development of skill and in relation to what? A useful step is the development of a curriculum map in which the major teaching themes are charted to see where they now exist, what additional inputs are necessary, and where experiences reinforce and deepen or where sheer duplication exists.

The place to start in field work seems to me is with faculty field instructors who can be charged with the development of a guide to content in family planning and who have shared with classroom faculty the task of identification and implementation of content to be taught.

While inspirational teaching will always be valued, in my view we cannot teach with tambourines; however, I can almost hear a student saying, "why not?" In Pakistan, minstrel singers are being used to bring the birth control message to villagers. For social work students, we can bring the birth control message through providing learning experiences that enable students to see the connections and relevance of family planning to social work's central concerns. We can thus capitalize on their idealism and passionate conviction about the need for improving the quality of life.

Appendix

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PROGRAM

<u>Wednesday, June 18</u>	Morning Chairman	Joanna F. Gorman, M.S.S.W., Lecturer in Public Health and Social Welfare, University of California, Berkeley
8:30 - 9:15	Registration and coffee	
9:15 - 9:30	Institute Plan	Joanna F. Gorman
9:30 - 9:45	WELCOME	Mary E. Watts, M.S.W., Assistant Chief Medical Social Work Section, Health Services Division, Children's Bureau, Department of Health, Education and Welfare, Washington, D.C.
		William C. Reeves, Ph.D., M.P.H., Dean, School of Public Health, University of California, Berkeley
		Milton Chernin, Ph.D., Dean, School of Social Welfare, University of California, Berkeley
9:45 - 10:45	<u>Family Planning in the United States</u>	
	Speaker	Lee Rainwater, Ph.D., Professor of Sociology, Department of Sociology, Washington University, St. Louis, Mo.
10:45 - 11:00	Break	
11:00 - 12:00	<u>The Social Worker's Responsibility in Family Planning</u>	
	Speaker	Miriam F. Mednick, M.S.W., Lecturer, School of Social Work, University of Pennsylvania, Philadelphia, Penna.
12:00 - 1:30	Lunch (Lunch in the Residence Hall is served from 12:00 to 1:00 P.M.)	
	Afternoon Chairman	Aaron Smith, M.S.W., M.P.H., Consultant Service and Programs for the Retarded, Santa Clara County Welfare Department, San Jose, Calif.
1:30 - 2:15	<u>Ethnic and Cultural Perspectives on Family Planning Service</u>	
	Speaker	Broadus N. Butler, Ph.D., Dean, College of Arts and Sciences, Texas Southern University, Houston, Texas

2:15 - 3:00

Ethnic and Cultural Perspectives - Panel Discussion

Aaron Smith, M.S.W., M.P.H., Moderator

Broadus N. Butler, Ph.D

C. Mayhew Derryberry, Ph.D.
 Professor of Health Education-in-Residence
 School of Public Health
 University of California, Berkeley

Faustina Solis, M.S.W., Coordinator
 Farm Workers Health Service
 Bureau of Maternal and Child Health
 California State Department of Public Health
 Berkeley, California

3:00 - 3:30

Coffee break

3:30 - 4:30

Panel Discussion - Audience Interchange (continued)

5:30 - 6:30

No Host Social Hour

6:30

Dinner

The Durant Hotel
 2600 Durant Avenue
 Berkeley, California

Thursday, June 19

Morning Edwin M. Gold, M.D., Professor-in-
 Chairman Residence of Maternal and Child Health
 School of Public Health
 University of California, Berkeley

9:00 - 9:30

Family Planning: One Part of Comprehensive
Maternal and Child Health Care

Speaker Helen M. Wallace, M.D., M.P.H.
 Professor of Maternal and Child Health
 School of Public Health
 University of California, Berkeley

9:30 - 10:30

Medical Aspects of Family Planning

Speaker Sadja Goldsmith, M.D., Director
 Teenage Clinic, Planned Parenthood-
 World Population, San Francisco, Calif.

10:30 - 11:00

Coffee break

11:00 - 11:30

Psychologic, Behavioral and Cultural Aspects of
Oral Contraception

Speaker Edwin M. Gold, M.D.

11:30 - 12:00

Discussion

Edwin M. Gold, M.D.
 Sadjia Goldsmith, M.D.
 Helen M. Wallace, M.D., M.P.H.

12:00 - 1:15

Lunch

Afternoon Samuel W. Dooley, M.D., Clinical
 Chairman Professor of Maternal and Child Health
 School of Public Health
 University of California, Berkeley

1:15 - 3:00

Counseling of Patients: Focusing on Professional and Patients' Attitudes and Feelings (Demonstration)

Speaker Lucille R. Wolf, R.N., Director
 Family Planning Unit
 Los Angeles County General Hospital
 Los Angeles, California

Discussion

3:00 - 3:30

Coffee break

3:30 - 5:00

The Social Worker's Role in Family Planning: Services to FamiliesIdaho Maternity and Infant Care Project

Speaker Spencer B. Wheatley, M.S.W., Chief
 Clinical Social Worker, Maternity and
 Infant Care Project, Idaho State
 Department of Public Health, Boise, Idaho

Factors Influencing Use of Contraception at the Nanakuli and Palolo Family Planning Clinics

Speaker Kazuyo T. Kumabe, M.S.W.
 Associate Professor, School of Social
 Work, University of Hawaii, Honolulu,
 Hawaii

Discussion

5:30 - 6:15

Dinner (For those staying in Residence Hall)

Friday, June 20

Morning Kathleen Johnson, M.S.W., Medical
 Chairman Social Consultant, Region IX,
 Children's Bureau, San Francisco,
 California

9:00 - 10:15

The Social Worker's Role in Family Planning: Services to Families (continued)

When Planning Fails: Abortion Counseling in a
Planned Parenthood Clinic

Speaker Leah Potts, M.S.W., Planned Parenthood-
World Population, Oakland, California

Genetic Counseling as Part of a Mental
Retardation Service

Speaker Sylvia Schild, D.S.W., Assistant
Professor, Department of Sociology,
California State College,
Los Angeles, California

Denver Family Health Services in Family Planning

Speaker Jane Collins, M.S.W., Director of
Social Services, Denver Department of
Health and Hospitals, Denver, Colorado

Discussion

10:15 - 10:45

Coffee break

10:45 - 12:00

The Team Approach to Family Planning

Kathleen A. Malloy, M.D., M.P.H., Director
James Jackson, M.D., Gynecologist
Laura Anderson, M.P.H., Coordinator-Health
Educator
Alvina Baranco, P.H.N., Public Health Nurse
Janice Friesen, M.S.W., Social Worker
AIDES: Ida Castillo
Jean Brooks
Emma L. Hunter
Maternity and Infant Care Project
Berkeley City Health Department
Berkeley, California

12:00 - 1:15

Lunch

Afternoon Joanna F. Gorman
Chairman

1:15 - 2:15

Education of Social Workers for
Family Planning Services

Educating the Social Worker - Staff Development

Speaker Alice M. Varela, M.S.W., M.P.H.,
Director, Social Service Division,
Health Insurance Plan of Greater
New York, New York

2:15 - 3:15

Educating the Social Worker - Schools of
Social Work Curriculum

Speaker Florence Haselkorn, M.S.W., Professor,
School of Social Work,
Adelphi University
Garden City, Long Island, New York

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